

HEALTH CARE REFORM

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Health Care Reform, Serial 103-88,...

HEARINGS
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES
ONE HUNDRED THIRD CONGRESS

VOLUME IX

President's Health Care Reform: Changes to the Medicare Program

NOVEMBER 23, 1993

Issues Relating to Managed Care

FEBRUARY 2, 1994

Serial 103-88

Printed for the use of the Committee on Ways and Means



SUBCOMMITTEE ON HEALTH
OF THE COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

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CONTENTS

PRESIDENT'S HEALTH CARE REFORM: CHANGES TO THE MEDICARE PROGRAM—NOVEMBER 23, 1993

	Page
Press releases announcing the hearings	2

WITNESSES

U.S. Department of Health and Human Services, Hon. Bruce C. Vladeck, Administrator, Health Care Financing Administration	8
Prospective Payment Assessment Commission, Stuart H. Altman, Ph.D., Chairman, and Donald Young, M.D., Executive Director	64
Physician Payment Review Commission, John M. Eisenberg, M.D., Chairman, and Paul B. Ginsburg, Ph.D., Executive Director	81

American Association of Retired Persons, Judith Brown	103
American Clinical Laboratory Association, Hope Foster	186
American College of Physicians, Howard B. Shapiro	178
American College of Radiology, K.K. Wallace, M.D.	164
American College of Surgeons, Stephen R.T. Evans, M.D.	157
American Health Care Association, Paul Willging	214
American Hospital Association, Thomas J. Lewis	13
American Medical Association, William E. Jacott, M.D., and Janet Horan	122
Hom-Ox-Equip Co., Michael R. Tracey	221
Inter-American Dialysis Institute, Mark Zawiski	206
Minnesota Association of Home Medical Equipment Suppliers, Michael R. Tracey	221
National Association for Home Care, Val J. Halamandaris	198
National Association of Medical Equipment Suppliers, Michael R. Tracey	221
National Committee to Preserve Social Security and Medicare, Martha McSteen	113
National Medical Association, Tracy M. Walton, Jr., M.D.	142
National Renal Administrators Association, Mark Zawiski	206
Society for Cardiovascular and Interventional Radiology, Gordon K. McLean, M.D.	169
Thomas Jefferson University Hospital, Thomas J. Lewis	131

SUBMISSIONS FOR THE RECORD

ABC Home Health Services, Inc., Joel V. Mills, letter and attachments	232
American Academy of Physician Assistants, statement	245
American Association for Clinical Chemistry, statement	249
American Association of Kidney Patients, A. Peter Lundin, M.D., statement ...	251
American Federation of Home Health Agencies, Joel V. Mills, letter and attachments	232
American Medical Technologists, Joyce H. Lybrand, statement	252
American Society of Clinical Pathologists, Rex B. Conn, M.D., statement	255
Bauer, Ken, Hinsdale Hospital, Hinsdale, Ill., letter	266
Brase, Stephen J., Nichols Institute, San Juan Capistrano, Calif., letter	276
Conn, Rex B., M.D., American Society of Clinical Pathologists, statement	255
Greater New York Hospital Association, Kenneth E. Raske, statement and attachment	259
Hinsdale Hospital, Hinsdale, Ill., Ken Bauer, letter	266

IV

	Page
Lundin, A. Peter, M.D., American Association of Kidney Patients, statement ..	251
Lybrand, Joyce H., American Medical Technologists, statement	252
Metropolitan Chicago Healthcare Council, statement	268
Mills, Joel V., ABC Home Health Services, Inc., and American Federation of Home Health Agencies, letter and attachments	232
National Association of Rehabilitation Facilities, Rob Schwartz, statement and attachments	270
Nichols Institute, San Juan Capistrano, Calif., Stephen J. Brase, letter	276
Raske, Kenneth E., Greater New York Hospital Association, statement and attachment	259
Schwartz, Rob, National Association of Rehabilitation Facilities, statement and attachments	270
Sundquist, Hon. Don, a Representative in Congress from the State of Ten- nessee, statement and attachments	279

ISSUES RELATING TO MANAGED CARE—FEBRUARY 2, 1994

Press release of Friday, January 21, 1994, announcing the hearing	292
---	-----

WITNESSES

U.S. Department of Health and Human Services:	
Hon. Philip R. Lee, M.D., Assistant Secretary for Health	327
Hon. Bruce C. Vladeck, Ph.D., Administrator, Health Care Financing Administration	330
U.S. General Accounting Office, Mark Nadel, Associate Director for National and Public Health Issues, Division of Health, Education and Human Ser- vices; accompanied by Michael Gutowski, Assistant Director, John E. Dicken, Evaluator, and Ed Stropko, Assistant Director for Health Financing and Policy	369

American Group Practice Association:	
Robert C. Montgomery, M.D.	438
James L. Reinertsen, M.D.	454
Arizona Health Care Cost Containment System, Donald F. Schaller, M.D.	479
California Pacific Medical Center, G. Aubrey Serfling	456
Community Health Group, Thomas D. Smith	509
Group Health Association of America, Karen Ignagni	471
Health Systems Minnesota, James L. Reinertsen, M.D.	454
Henry J. Kaiser Family Foundation, Diane Rowland	388
Kaiser Commission on the Future of Medicaid, Diane Rowland	388
Lucy Johns, San Francisco, Calif.	422
MeritCare Medical Group, Robert C. Montgomery, M.D.	438
Neighborhood Health Plan, Jay Harrington	493
New Yorkers for Accessible Health Coverage, Susan M. Dooha	401
Pennsylvania Health Law Project, Michael J. Campbell, and Ann Torregrossa	412

SUBMISSIONS FOR THE RECORD

American Managed Care and Review Association, Charles W. Stellar, letter ...	529
American Pain Society, American Academy of Pain Medicine, and American Association for the Study of Headache, joint statement	535
Electronic Data Systems, Inc. (EDS), Alice Lusk, statement	539
HealthNetwork, Inc.; American Association of Preferred Provider Organiza- tions; and American Managed Care and Review Association, George C. Phillips, Jr., joint statement	542
National Association of Rehabilitation Facilities, Rob Schwartz, statement	546
Wisconsin Independent Physicians Group, Inc., Charlette L. Beyerl	552

PRESIDENT'S HEALTH CARE REFORM PROPOSALS: CHANGES TO THE MEDICARE PROGRAM

TUESDAY, NOVEMBER 23, 1993

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.

The subcommittee met, pursuant to call, at 10:05 a.m., in room 1100, Longworth House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

[The press releases announcing the hearing follow:]

FOR IMMEDIATE RELEASE
TUESDAY, NOVEMBER 9, 1993

PRESS RELEASE #22
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1114 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES HEARINGS
ON
THE PRESIDENT'S HEALTH CARE REFORM PROPOSALS:
CHANGES TO THE MEDICARE PROGRAM

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a hearing on issues relating to Medicare changes in the President's health care reform proposals.

The hearing will be held on Tuesday, November 23, 1993, at 10:00 a.m. in the main Committee hearing room, 1100 Longworth House Office Building.

Witnesses for these hearings will include both invited witnesses and individuals and organizations who have requested an opportunity to testify before the Subcommittee. All witnesses who will appear at these hearings will be notified in advance by the staff.

BACKGROUND:

The President's health care reform proposal is intended to achieve \$124 billion in Medicare savings in the years 1996 through 2000, according to Administration estimates. To achieve these savings, the President proposes the following changes:

Proposals Relating to Part A

1. Reduction of the hospital inflation update to market basket minus two percent for fiscal years 1997-2000;
2. Reduction of the indirect medical education (IME) adjustment;
3. Permanent reduction in prospective Federal and hospital-specific rates for capital;
4. Reduction of the capital payment update factor to recapture excessive capital payments prior to 1992;
5. Modification and phase-out of the hospital disproportionate share payments by January 1, 1998;
6. Establishment of a moratorium on designating new long-term care hospitals; and
7. Reduction of the skilled nursing facility (SNF) cost limits.

Proposals Relating to Part B

1. Establishment of cumulative expenditure goals for physicians services, and replacement of the current use of historical volume and intensity in the default Medicare Volume Performance Standard formula with per capita growth in real Gross Domestic Product (plus 1.5 percentage points for primary care services);
2. Reduction of the Resource-Based Relative Value Scale update by three percent in 1995, except for primary care which would be held harmless;

3. Establishment of limits on payments to physicians of high cost hospital staffs;
4. Establishment of Medicare primary care incentives;
5. Elimination of the so-called "extra-payments" to hospitals for outpatient hospital services; and
6. Establishment of competitive bidding for certain Medicare Part B services.

Proposals Relating to Part A and B

1. Modification of Medicare secondary payer policies affecting working beneficiaries;
2. Reduction of home health cost limits;
3. Modification of payments to health maintenance organizations;
4. Establishment of "Centers of excellence"; and
5. Restructuring of Medicare payments for direct graduate medical education (GME).

Proposals Relating to Beneficiary Payments

1. Permanent extension of the 25-percent rule for Part B Medicare premium;
2. Establishment of a 20-percent copayment for laboratory services;
3. Requirement of a 10-percent coinsurance on home health visits for visits provided more than 30 days after hospital discharge; and
4. Establishment of an income-related Part B premium.

The dates, times, and rooms for subsequent hearings will be announced at a later date. Oral testimony will be heard from invited and public witnesses during the course of the Subcommittee hearings on the President's proposals. For further details about these hearings, see Subcommittee press release #18, dated September 30, 1993.

FOR IMMEDIATE RELEASE
THURSDAY, SEPTEMBER 30, 1993

PRESS RELEASE #18
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES HEARINGS
ON
HEALTH CARE REFORM:
THE PRESIDENT'S HEALTH CARE REFORM PROPOSALS

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a series of hearings on issues relating to the President's health care reform proposals.

The hearings will begin on Thursday, October 7, 1993, at 10:00 a.m. in the main Committee hearing room, 1100 Longworth House Office Building. They will continue on Tuesday, October 12, 1993, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m. Subsequent hearings will be announced at a later date.

In announcing the hearings, Chairman Stark said: "The President's health care reform plan presents a comprehensive response to the nation's most pressing problem. The plan would commit the nation to universal health coverage and to cost containment -- goals we have been seeking for many years. The President's proposals are complex, and we want to explore this plan and the alternatives to it, thoroughly, before proceeding to mark up a bill. We, therefore, expect to hold hearings to examine various aspects of the proposals throughout the fall of 1993."

Oral testimony will be heard from invited and public witnesses during the course of the Subcommittee hearings on the President's proposals.

BACKGROUND:

The first hearing, scheduled for October 7, will include testimony from representatives of affected groups, including labor unions, health care providers, and health insurers.

Testimony from Administration experts on various aspects of the President's proposals, including benefits, coverage, low-income subsidies, cost containment, governance, and Medicare proposals, will be heard by the Subcommittee at the next two hearings. The first day of Administration witnesses will be held on October 12, and the second day will be announced in a later press release.

At subsequent hearings the Subcommittee will receive testimony from Members of Congress and from representatives of other affected groups, including consumer and employer groups.

Testimony will be heard at additional hearings to focus on a series of priority health reform issues, including:

- (1) Role of State governments and the Federal Government, including the role and functions of the proposed National Health Board, the Department of Health and Human Services, and other Federal agencies;
- (2) Role and functions of the proposed health alliances;
- (3) Health cost containment, including premium caps and alternative mechanisms;
- (4) Proposed insurance reforms and their impact, risk selection, and risk adjustment;

(MORE)

- (5) Impact of the plan on underserved inner-city and rural areas;
- (6) Impact of the plan on low-income populations generally;
- (7) Medicare savings proposals;
- (8) Impact of the plan on the structure and future of the Medicare program, including the proposed Medicare drug benefit;
- (9) Alternatives to the plan, including single-payer options, and other managed-competition options;
- (10) Administrative simplification under the plan;
- (11) Quality assurance;
- (12) Fraud and abuse measures;
- (13) Retiree health benefits;
- (14) Long-term care benefit;
- (15) Proposed standard health benefit package;
- (16) Graduate medical education and academic medical centers;
- (17) Impact of the plan on other affected groups and individuals.

Hearings also will be scheduled by the full Committee on Ways and Means to consider financing issues (other than Medicare savings proposals) and other tax-related matters.

DETAILS FOR SUBMISSION OF REQUESTS TO BE HEARD:

Members of Congress, individuals and organizations interested in presenting oral testimony before the Subcommittee must submit their requests to be heard by telephone to Harriett Lawler, Diane Kirkland or Karen Ponsurick [(202) 225-1721] no later than the close of business on Friday, October 15, 1993, to be followed by a formal written request to Janice Mays, Chief Counsel and Staff Director, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. The staff will notify by telephone those scheduled to appear as soon as possible after the filing deadline and after additional hearings have been scheduled.

Individuals and organizations must specify in their requests to testify on which topic they would like to be heard. Given the limited time for the Subcommittee to hear from public witnesses, it is likely that witnesses will be restricted to one scheduled appearance before the Subcommittee. Additional comments on other aspects of the President's proposals may be submitted for the printed record of the appropriate hearing.

It is urged that persons and organizations having a common position make every effort to designate one spokesperson to represent them in order for the Subcommittee to hear as many points of view as possible. Witnesses are reminded that the Subcommittee has held extensive hearings on various health reform issues earlier this year. To the extent possible, witnesses need not restate previous testimony heard by the Subcommittee.

Time for oral presentations will be strictly limited with the understanding that a more detailed statement may be included in the printed record of the hearing. In addition, witnesses may be grouped as panelists with strict time limitations for each panelist.

(MORE)

In order to assure the most productive use of the limited amount of time available to question hearing witnesses, all witnesses scheduled to appear before the Subcommittee are requested to submit 300 copies of their prepared statements to the Subcommittee office, room 1114 Longworth House Office Building, at least 24 hours in advance of the scheduled appearance. Failure to comply with this requirement may result in the witness being denied the opportunity to testify in person.

WRITTEN STATEMENTS IN LIEU OF PERSONAL APPEARANCE:

Persons submitting written statements for the printed record of the hearing should submit at least six (6) copies of their statements by the close of business on the last day of the hearings, to Janice Mays, Chief Counsel and Staff Director, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, room 1114 Longworth House Office Building, before the final hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will ~~not~~ be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

★ ★ ★ ★ ★

Chairman STARK. Good morning. If our guests could find seats. Today, the subcommittee continues its series of hearings on the administration's health care reform proposal. During this hearing, we will focus on issues related to Medicare savings in the President's health care reform proposal.

The President's plan would achieve substantial savings through reductions in the rate of growth in the Medicare program. According to administration estimates, the President's health care reform proposal would achieve \$124 billion in Medicare savings in the years 1996 through 2000.

The Chair has some concerns about the magnitude of these Medicare cuts in the President's plan. They are substantial and they come in the wake of \$56 billion in Medicare program cuts, some of which the administration had promised to use for childhood inoculation and they reneged on that promise, and the Chair is somewhat reluctant to adhere to the administration's request for cuts unless we can be assured that they will not have a deleterious effect on the Medicare program.

It is an extremely popular program, the most popular insurance program in the country, the most efficiently run, or it was under the Reagan and Bush administrations, an overhead of only 3 cents on the dollar. This subcommittee is committed to protecting the interests of Medicare beneficiaries as we move ahead with health care reform.

I am concerned about how Medicare beneficiaries will fare under the President's health care reform proposal. I intend to make sure that Medicare beneficiaries are not put at risk and that all Medicare reforms are within the framework of a thorough reorganization of the health care system.

I have doubts about the advisability of enacting a comprehensive benefit program for the under-65 population which is substantially more generous than the benefit package guaranteed under Medicare.

I hope this hearing will provide an opportunity for individuals and organizations to focus on these issues and other issues related to the Medicare savings.

I would like to say that this subcommittee, or the Chair at least, often admonished the previous administration about willfully attempting to discredit the Medicare system in an attempt to privatize it. I would hate to see the administration, of which I helped to elect, discredit the Medicare system through inattention and ineptness. That is not the case, but I am afraid that unless we focus on the current system and don't get sidetracked with reform, the Medicare system could be harmed from current neglect.

There are some present programs in the system that need attention, and we will get into the discussion of those later in the testimony.

Chairman STARK. Mr. Thomas.

Mr. THOMAS. Thank you, Mr. Chairman. It is always interesting to hear someone somewhat nostalgic for the previous period. When we were in it, the reaction wasn't quite the same.

My concern, Mr. Chairman, is along your lines, and that is not that I think we can't get some savings out of the Medicare area but that the attempt to do so be a realistic one in a real world context.

It does no one any good to throw numbers up on the wall and declare that by some way we are going to reach those numbers, and, by the way, those numbers are absolutely essential to bringing about the other changes that we are looking for, especially when the reductions in Medicare under the Clinton plan equal virtually the entire Medicare budget for fiscal year 1993—\$124 over 5 years; we are spending about \$130 billion now.

Those kinds of reductions I don't believe are achievable, not that we shouldn't pursue them, but that they simply aren't achievable in the current makeup of the Congress. That is why, Mr. Chairman, Senator Chafee and I on this side of the Capitol are introducing a bill which I think is far more reasonable in attempting to bring about some of the changes that most of us think would be desirable in the health care delivery system.

For example, in the Medicare area the attempt is to reduce it from the current 12 percent down to 9 percent over a 3 to 5 year period, which I think is an achievable reduction. The attempt to make sure that we mainstream the Medicare recipients into the regular program rather than enrich the regular program vis-a-vis the Medicare.

There are a number of things that I think we can achieve if we look at realistic goals, realistic timetables, and realistic solutions. One of my real concerns is that under the President's plan as introduced perhaps some of the targets that are essential are not as realistic as they should be, and I am looking forward to the testimony of one of the individuals, the Administrator of the Health Care Financing Administration, to can give us a handle on whether or not the numbers appear to be as unachievable as I believe they are.

Thank you, Mr. Chairman.

Chairman STARK. Our first witness is Bruce Vladeck, the Administrator of the Health Care Financing Administration. He has had a long and distinguished career as a health policy analyst and a manager at both the Federal, State, and private level. We look forward to Mr. Vladeck's testimony. Bruce, lead off.

**STATEMENT OF BRUCE C. VLADECK, ADMINISTRATOR,
HEALTH CARE FINANCING ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**

Mr. VLADECK. Thank you very much, Mr. Chairman.

Good morning, Mr. Thomas, Mr. McDermott. I am very pleased to be back again as part of our continuing discussion of the reform of the Nation's health care system. It is an exciting prospect, as I think I told you at the last hearing, that we are finally moving forward toward providing health care security to every American citizen.

We have submitted a complete formal statement for the record, if I could just begin with some introductory remarks.

Chairman STARK. Without objection, all witnesses' testimony today will appear in the record in their entirety, and we will encourage the witnesses to summarize or expand on their prepared testimony.

Mr. VLADECK. Thank you.

Today's topic is Medicare beneficiaries and how they will fare under the Health Security Act. When I appeared before you last

month, I emphasized that we are very committed to continuing high quality and reliable coverage for the elderly and disabled. That message bears repeating. This Administration and this Administrator have no intention of putting Medicare beneficiaries at risk. The Medicare reforms we are proposing will be within the framework of a thorough reorganization of the health care system in which everyone stands to gain.

Under the President's plan, the Medicare program will continue to offer health security to America's elderly and disabled citizens, only now with more choices than they have had before. Beneficiaries who are employed or are the spouse or dependent of someone who is employed will receive their health care coverage through regional health alliances.

These beneficiaries will be able to choose from among all the plans in the alliances and will pay the same premiums as everyone else. Medicare will automatically fill in plan cost sharing as the secondary payer for part A services. Beneficiaries may also obtain secondary coverage for part B services if they pay the part B premium. Once in the alliance, the beneficiary remains there for the entire year, even if the tie to employment ends. In that case, Medicare would pay the employer's share of the premium.

Individuals covered under an alliance who become eligible for Medicare will be permitted to remain in the alliance if they choose. If the plan is eligible for a risk contract with Medicare, the Medicare program will pay the plan the same amount it would have paid if the beneficiary had enrolled directly in a Medicare risk plan. The beneficiary will make up the difference between the plan premium and the Medicare payment.

Medicare-eligible individuals in the alliance may later choose to return to Medicare and remain there. For beneficiaries who choose the mainstream Medicare program, there will be expanded opportunities to participate in managed care and new legislation will make medigap policies more accessible.

The President's plan will require medigap insurers to accept all Medicare beneficiaries, regardless of age or health, at the same premium. Medigap insurers will, however, continue to be permitted to exclude preexisting conditions—but only for the first 6 months of a new policy.

To keep Medicare beneficiaries informed of the full array of options available to them, Medicare will have an annual open enrollment period, giving beneficiaries the opportunity to switch to new managed care plans or medigap policies. During this enrollment period, beneficiaries will be provided with comparison information so they can make informed choices. This open enrollment will be conducted by a third party to prevent managed care plans and medigap carriers from marketing selectively to healthier, low-risk individuals.

In addition to expanded options for health care delivery, the elderly and disabled will have access to two new benefits that will help with health care needs that are becoming more and more unaffordable and even catastrophic for some. Many elderly and disabled Americans enter nursing homes and other institutions when they would prefer to remain at home. Families often exhaust their savings trying to provide for disabled relatives.

Our plan will provide greater security for those in need of long-term care and their families by easing this financial burden through a new long-term care benefit. This is not part of the Medicare program but rather a joint State and Federal undertaking. Over time, this benefit will make more home and community-based services available to individuals, regardless of income, who are sufficiently disabled to qualify.

In addition, the Health Security Act will improve private long-term care insurance by establishing Federal standards which will be implemented and enforced under plans developed by States and approved by the Secretary. The cost to individuals of long-term care insurance—and any amounts paid by them for long-term care services under an insurance policy—will be excluded from taxable income.

Similarly, disabled individuals who are working will be eligible for a tax credit of up to the lesser amount of \$7,500 in personal assistance expenses or half of the taxpayer's earned income.

A new Medicare prescription drug benefit will have a major impact on the quality of life of the elderly. As in the comprehensive benefit package, the Medicare drug benefit will cover all drugs, biologicals and insulin approved by the Food and Drug Administration. Right now drug costs force some older Americans to choose between food and medicine. Making prescription drugs financially accessible to the elderly will reduce illnesses and hospital stays.

In the context of a plan that will bring down private sector costs, we can achieve Medicare savings without shifting costs or endangering beneficiaries' access to services. The President's plan, and virtually every Democratic and Republican health care plan that has been proposed, recognizes that we can save money by lowering the rate of growth in Medicare and Medicaid. Our bill identifies \$124.4 billion in specific line-by-line savings in the Medicare program. That is, \$124.4 billion to redirect into the health care system in the interests of all Americans and the Nation's economy.

While the amount of our proposed savings may seem high today, we must keep in mind they will be taken from a base line of \$1.2 trillion in projected Medicare spending in the period 1995 to 2000. What is more, these proposed savings will only reduce the growth in Medicare spending from triple the inflation rate to double that rate.

Lowering the rate of growth in Medicare spending is perhaps the most important thing we can do for beneficiaries. Lower expenditures mean that beneficiaries pay less out-of-pocket in the form of coinsurance and deductibles. It also means that future beneficiaries can look forward to a stronger, more financially sound Medicare program because reducing costs in both the Medicare program and the private sector will serve to improve the long-term integrity of the Medicare trust funds.

It was our intention to be as sensitive as possible when developing our savings proposals in the Medicare program, especially where beneficiaries are concerned. Although beneficiaries will contribute to slowing the growth of Medicare spending, they will also benefit from the elimination of balanced billing, making Medicare consistent with the plans in the alliances. These savings proposals

will result in lower part B premiums, saving beneficiaries almost \$10 billion over 6 years.

We have offered 28 proposals to reduce the rate of increase in Medicare spending. Many of these are extensions of expiring authorities, such as the Medicare secondary payer provisions and the reductions in the hospital payment update.

Another significant proportion of proposed savings result largely from eliminating or reducing provider payments that were originally intended to ease the financial pressures created by uncompensated care. Payments to hospitals for indirect medical education and disproportionate share adjustments are examples of such payments. With universal coverage, the volume of uncompensated care will shrink to a minimal amount.

The Health Security Act includes \$60.4 billion in savings from part A. I won't enumerate the proposals for you. Obviously, I would be happy to talk about any of them at any length in the course of the hearing.

Our part B proposals affecting providers will save just under \$40 billion over 6 years, and again, I will spare you the entire list, although I am happy to talk about any part of it.

We then propose to save \$17.2 billion in proposals that cut across parts A and B, and again, there are about a half dozen of those which we can discuss. And there is one proposal that will produce \$7.3 billion in new revenues by requiring State and local government employees, who are now exempt, to pay the hospital insurance payroll tax.

The President's health security plan includes important Medicare proposals that reinforce the program while at the same time reduce its rate of growth. We believe these changes in the program are attainable and necessary for successful reform of the health care system as a whole.

We do have the resources to meet the health care needs of all our citizens if we spend our dollars more wisely. With everyone's willingness to participate, we can afford universal coverage without compromising quality or limiting the availability of necessary health care services for the elderly population or any other population in our country.

I look forward to working with you in the months ahead to forge a consensus on health care reform that promotes the good health of our citizens and strengthens our national productivity. I thank you very much, and, obviously, I am happy to respond to any questions you might have.

[The prepared statement and attachments follow:]

**TESTIMONY OF BRUCE C. VLADECK
HEALTH CARE FINANCING ADMINISTRATION**

Mr. Chairman and Members of the Subcommittee:

Thank you for inviting me to appear before you again today. I view each of these hearings as another opportunity to press forward in the reform of the country's health care system. It's an exciting prospect that we are finally advancing towards providing health care security to every American citizen.

Today I'm here to discuss elderly and disabled American citizens in particular, and how they will fare under the Health Security Act. When I appeared before you last month to discuss how the President's plan will be financed, I emphasized that we are very committed to continuing high quality and reliable coverage for the elderly and other Medicare beneficiaries.

That message bears repeating. This Administration has no intention of putting Medicare beneficiaries at risk. The Medicare reforms we are proposing will be within the framework of a thorough reorganization of the health care system in which everyone stands to gain.

This morning I will talk about how the Medicare program will be strengthened and enhanced by new benefits and expanded choices for health care delivery. And I will also discuss our savings proposals for the Medicare program which, in large part, will be facilitated by the more efficient health care environment created by the Health Security Act.

Options for Medicare Beneficiaries

Under the President's plan, the Medicare program will continue to offer health security to America's elderly and disabled citizens — only now with more health care options than they've ever had before.

Beneficiaries who are employed, or who are the spouse or the dependent of someone who is employed, will receive their health care coverage through regional health care alliances. These beneficiaries will be able to choose from among all the plans in their alliances and will be charged the same premium as everyone else. Medicare will automatically fill in plan cost sharing as the secondary payer for Part A services. Beneficiaries may also obtain secondary coverage for Part B services if they pay the Part B premium. Once in the alliance, the beneficiary will be there for the entire year even if the tie to employment ends. In that case, Medicare will pay the employer share of the premium.

Individuals covered under an alliance who become eligible for Medicare will be permitted to remain in the alliance if they choose — if the plan they are enrolled in has a risk contract with Medicare or is eligible to have a risk contract with Medicare. The Medicare program will pay the plan the same amount it would have paid if the beneficiary had enrolled in a Medicare risk plan. The beneficiary will make up the difference between the plan premium and the Medicare payment. Medicare eligible individuals in the alliance may later choose to return to Medicare and remain enrolled there.

For beneficiaries who choose Medicare, there will be expanded opportunities to participate in managed care and new laws making Medigap policies more accessible. The President's plan will require Medigap insurers to accept all Medicare beneficiaries, regardless of age or health, at the same premium. Medigap insurers will, however, continue to be permitted to exclude preexisting conditions, but only for the first six months of the first new policy.

To keep Medicare beneficiaries informed of the full array of managed care and Medigap options available to them, Medicare will hold an annual open enrollment giving beneficiaries the opportunity to switch to new plans or policies. During this enrollment period, beneficiaries will be provided with comparison information on every available managed care plan and Medigap policy so they can make informed choices. This open enrollment will be conducted by a third party to prevent managed care plans and Medigap insurers from marketing selectively to healthier,

low-risk individuals.

As I explained during my last hearing, States can apply to the Secretary for approval to integrate Medicare beneficiaries into their regional alliance or single-payer systems. We will approve such requests only if the State is capable of meeting certain strong guarantees. First, neither the beneficiaries nor the government will be financially worse off. Second, quality will be equal or better. And finally, at least one fee-for-service plan must be available to the beneficiaries at no greater out-of-pocket cost than they would pay under Medicare.

New Benefits

In addition to expanded options for health care delivery, the elderly and disabled will have access to two new benefits that will help them with health care needs that are becoming more and more unaffordable — and even catastrophic for some.

Many elderly and disabled Americans enter nursing homes and other institutions when they would prefer to remain at home. And families often exhaust their savings trying to provide for disabled relatives. Our plan will provide greater security for those in need of long-term care and their families by easing this financial burden through a new **long-term care** benefit. This is not a benefit sponsored by Medicare, but rather jointly sponsored by the State and Federal governments. Over time, this benefit will make available more home and community-based services to individuals, regardless of income, who are sufficiently disabled to qualify.

In addition, the Health Security Act will improve private long-term care insurance by establishing federal standards which will be implemented and enforced under plans developed by States and approved by the Secretary. And the cost to individuals of long-term care insurance and any amounts paid by them for long-term care services under an insurance policy will be excluded from taxable income. Similarly, disabled individuals who are working will be eligible for a tax credit of up to the lesser of \$7,500 in personal assistance expenses or half of the taxpayers earned income. **A new Medicare prescription drug benefit** will have a major impact on the quality of life of the elderly. Right now, drug costs force some older Americans to choose between food and medicine. Making prescription drugs financially accessible to the elderly will help eliminate illnesses and unneeded hospital stays.

As in the comprehensive benefit package, the Medicare drug benefit will cover all drugs, biological products and insulin approved by the Food and Drug Administration. Since the drug benefit will be incorporated into Part B, Medicare beneficiaries will see an increase in their Part B premium. They will also have to meet an annual drug deductible of \$250. As with other Part B benefits, beneficiaries will be responsible for 20 percent coinsurance on all prescription drugs. Unlike other part B services, however, there will be a \$1,000 limit on beneficiary out-of-pocket spending. Low-income Medicaid and Qualified Medicare Beneficiaries will continue to have their cost-sharing paid by Medicaid.

The Medicare prescription drug program will benefit from the expertise and success we have already achieved in the current Medicaid drug program. Drug manufacturers will have to sign rebate agreements with the Secretary, similar to those they sign now under the Medicaid program. An additional rebate will be levied for drugs whose prices increase faster than the rate of inflation. For new drugs, the Secretary will have authority to negotiate with manufacturers for a discounted Medicare price. Medicare will cover any new drugs for which the Secretary and manufacturers can agree on a satisfactory price.

I should point out that we adopted this approach of rebates, discounts and negotiated prices because the pharmaceutical industry was adamantly opposed to Medicare's use of private sector strategies to hold down prescription drug costs. In particular, the industry opposed Medicare's use of negotiated formularies which private plans will use to receive prescription discounts. Today, private hospitals and

HMOs negotiate with manufacturers for price discounts in return for covering that manufacturer's drugs on their formulary. To avoid distorting the outcome of other market negotiations, we agreed to adopt the approach we did. Given the variety of approaches, we will be pleased to continue discussions with this subcommittee and the industry on the most appropriate strategies for protecting the Medicare program and the taxpayer while assuring access to needed medications for the elderly and the disabled.

We have a good track record from experience in the Medicaid program with drug manufacturers and States in developing working relationships, establishing new data and reporting systems, and implementing billing and processing systems. The large volume of drug claims that will result from this benefit will be best handled by electronic on-line systems in pharmacies for drug utilization review and claims payment purposes. While complex, an electronic drug claims processing system is much more achievable now than 5 years ago, when we were working on the Medicare catastrophic drug benefit. Currently, Medicare leads the industry in electronic claims processing. The system could facilitate the establishment of a drug utilization review program to identify duplicate prescriptions or potential adverse reactions, if analysis suggests this is our appropriate choice.

Savings In Medicare

In the context of a plan that will bring down private sector costs, we can achieve Medicare savings without shifting costs or endangering beneficiaries' access to services. The President's plan — and virtually every Democratic and Republican health care plan that has been proposed — recognizes that we can save money by lowering the rate of growth in Medicare and Medicaid. Our bill identifies \$124.4 billion in specific, scorable, line-by-line savings in the Medicare program. That's \$124.4 billion dollars to redirect in the interest of the health of all Americans and in the interest of the Nation's economy.

This amount is comparable to the savings proposed by the Senate Republican plan, and less than the savings called for by some single-payer proposals. And while the amount of our savings may seem high today, we must keep in mind they will be taken from a future base of \$1.2 trillion in projected Medicare spending over the years 1995 to 2000. What's more, the \$124.4 billion will only reduce the growth in Medicare spending from triple the inflation rate to double.

Lowering the rate of growth in Medicare program expenditures is perhaps the most important thing we can do for beneficiaries. Lower expenditures over time mean that beneficiaries pay less out-of-pocket in the form of coinsurance and deductibles. It also means that future Medicare beneficiaries can look forward to a stronger, more financially sound, Medicare program because reducing costs in both sectors of the economy will serve to improve the long-term integrity of the Medicare trust funds.

It was our intention to be as sensitive as possible when developing our savings proposals in the Medicare program — especially where beneficiaries are concerned. The Medicare savings affecting beneficiaries will be a result of increasing premiums for beneficiaries with incomes in excess of \$90,000 for individuals and \$115,000 for couples, continuing the current policy on premium levels, and from charging cost sharing for Medicare home health and laboratory services which, unlike most Medicare services, are now provided without cost sharing. However, beneficiaries will no longer be subject to balance billing, making Medicare more consistent with alliance plans. These saving proposals will result in lower part B premiums, saving beneficiaries almost \$10 billion over 6 years.

The Administration has offered 28 proposals to improve the operations of the Medicare program. Many of these proposals are extensions of expiring authorities such as the Medicare secondary payer provisions and the reduction in the hospital market basket.

Another significant portion of the savings from these proposals are largely a result of eliminating or reducing payments to providers that were originally intended to ease the financial pressures created by uncompensated care. Payments to hospitals for indirect medical education and disproportionate share adjustments are examples of such payments. With universal coverage, virtually all care will be compensated.

Medicare Part A

The Health Security Act includes the following proposals affecting Medicare Part A services.

- **Reduce the update for PPS hospitals** by a further 1.5 percentage points in fiscal year 1997 (for a total of 2.0) and maintain this 2.0 percentage point reduction in fiscal years 1998 through 2000. We are projecting market baskets of 5 percent a year in fiscal years 1996 through 2000. This proposal will give hospitals updates of 3 percent a year (and more when considering case mix increase, which is in the range of 2 percent a year). This proposal will save \$18.16 billion over six years.
- **Reduce the indirect medical education adjustment factor** from 7.7 percent to 3.0 percent in fiscal year 1996 and increase that amount by increases in the alliance premiums thereafter. Studies over the years have shown that the current level of the IME adjustment is not justified and that it overcompensates teaching hospitals for their indirect teaching costs. At this level, Medicare will contribute about one-half of the payments to the Academic Health Center pool established by the Health Security Act. Six year savings for this proposal will be \$17.84 billion.
- **Reduce Medicare hospital capital payments.** This proposal combines three inpatient capital adjustments. The first adjustment reduces rates to reflect more accurate base year data and cost projections. These reductions are based on more recent data on both the cost of capital and in the rate of increase in capital costs per discharge. The second proposal reduces the update factor to account for excess capital spending prior to implementing the capital prospective payment system. Third, we will also initiate a 15 percent reduction in payments for capital in non-PPS hospitals. Six year savings will be \$10.325 billion.
- **Replace the current disproportionate share hospital program with a new program** as States enter into the system. The new program will assist hospitals serving the largest share of low-income patients. Hospitals that have a disproportionate share of low-income patients will receive an additional payment from Medicare. Studies show that the additional payment overcompensates for the higher costs associated with treating low-income patients. Six year savings will be \$14.63 billion.
- **Eliminate prospective payments system exemptions for new long-term care hospitals.** Long-term care hospitals, which have an average length of stay of over 25 days, are currently exempt from the PPS system, receiving cost-based reimbursement from Medicare, subject to TEFRA limits. This proposal will establish a moratorium on new long-term care hospitals receiving exemptions from the Medicare prospective payment system. Six year savings for this proposal will be \$530 million.
- **Assure that OBRA 93 skilled nursing facility savings are retained.** OBRA 93 established a two-year freeze on updates to the SNF limits. However a "catch-up" would occur when the SNF freeze expires on October 1, 1995 -- limiting the savings to two years. This proposal will eliminate the inflation "catch-up", and provide permanent savings by recalculating the percent of the mean that would produce the same amount of savings as if the freeze were continued. This proposal will result in a 6 year savings of \$830 million.

Medicare Part B

Proposals to reduce the growth in Part B spending in the President's plan include the following:

- **Modify Medicare volume performance standard volume/intensity factor.** Beginning with the fiscal year 1995 MVPS, replace the current five-year volume/intensity factor and the performance standard factor with the five-year growth in real gross domestic product GDP per capita for surgery and other physician services, and with real GDP per capita plus 1.5 percentage points for primary care services. The current method of setting the MVPS results in excessively high targets and inappropriate updates. Using real GDP per capita to set the MVPS ties growth in physician services to real growth in the economy. This proposal is consistent with a recommendation of the Physician Payment Review Commission. The six year savings for this proposal will be \$6.1 billion. Beneficiaries will experience savings of about 25 percent of this amount through lower cost-sharing liabilities.
- **Establish cumulative MVPS rates of increase** for each of the three separate categories of service: primary care, surgery, and all other services. Currently, the MVPS for each year is based on the prior year's actual rate of growth in outlays without regard to the prior year's target rate of growth in outlays. This proposal will link the MVPS for each category of service to a base year (fiscal year 1995). This approach assures more predictability and control over expenditures for both physicians and the Federal government. This proposal will save \$5.815 billion over six years. Beneficiaries will experience savings of about 25 percent of this amount through lower cost-sharing liabilities.
- **Reduce the 1995 non-primary care physician conversion factor by 3 percent.** This reflects our belief that the 1994 update will be excessive because the default formula for computing the MVPS factored in unreasonably high volume and intensity levels. Had the fiscal year 1992 MVPS formula provided for volume and intensity allowances consistent with projections in the Trustees Reports or based on GDP growth as we are now recommending, the resultant MVPS and the 1994 update would have been lower. The savings for this proposal over 6 years will be \$2.975 billion. Beneficiaries will experience savings of about 25 percent of this amount through lower cost-sharing liabilities.
- **Eliminate the hospital outpatient overpayment.** Under current law, Medicare pays for hospital outpatient ambulatory surgery, radiology, and other diagnostic services using a blended payment methodology. Because of a flaw in the statutory payment formula, which assumes a lower coinsurance payment than is actually made, hospitals receive more than the intended payment amount. This proposal will eliminate the flaw in the payment methodology and the resulting overpayment, effective July, 1, 1994. The 6 year savings for this proposal will yield \$12.61 billion.
- **Competitively bid for laboratory services.** Under current law, clinical laboratory services are paid on the basis of carrier fee schedules which are subject to national limits. We propose that clinical laboratory services be paid on the basis of competitive bidding as of January 1, 1995. Competitive bidding will help Medicare to obtain a price closer to the true market price, will allow changes in technology and other changes in input prices to be factored into the price structure directly, and will help Medicare get the same discounts now given to non-Medicare business. Savings for this proposal over 6 years will be \$1.59 billion.
- **Competitively bid for certain durable medical equipment items, MRIs and CAT scans.** Currently Medicare is not paying market prices for these items, nor is there a reliable mechanism to determine such a price under current authority. Moreover, the GAO has reported that high Medicare payment rates for MRIs foster excess capacity by allowing providers to realize profits at low operational

volumes. Competitive bidding will reveal the most efficient sources of supply and will establish market prices for these items and services. This proposal will yield a 6 year savings of \$1.32 billion.

- **Increase income-related Part B premium.** Under this proposal, effective January 1, 1996, beneficiaries with modified adjusted gross incomes over \$90,000 and couples with adjusted gross incomes over \$115,000 will pay a higher premium. The maximum premium will equal 75 percent of program costs. They will still receive a 25 percent subsidy. Under current law, all Medicare beneficiaries regardless of income who enroll in a timely manner, receive a subsidy from taxpayers equal to 75 percent of program costs, which will be about \$1,600 in 1996. General taxpayers should not have to heavily subsidize the costs of health care of the nation's high-income individuals. This proposal will require high-income Medicare beneficiaries to pay a progressively higher Part B premium and establish more equity in the financing of the program. This proposal will produce \$4.24 billion in savings over 6 years.
- **Re-establish a 20 percent coinsurance on all Part B clinical laboratory services,** effective January 1, 1995. Clinical laboratory services are the only diagnostic services under Medicare for which coinsurance does not apply. Physicians may now order an excessive amount of tests when they know that the service is free to the beneficiary. Reestablishing coinsurance will make cost-sharing requirements uniform across Part B. Coinsurance will provide incentives for the provision of appropriate tests. Six-year savings for this proposal will be \$7.59 billion.
- **Extend SMI premium to finance 25 percent of program costs.** This proposal will extend the current 25 percent policy through the year 2000 and will save \$3.81 billion over 6 years.
- **Limit payments to high-cost medical staffs.** As a national mechanism, the MVPS fails to adjust adequately for variations in physician practice patterns across communities or regions. Currently there is wide variation in Medicare's physician expenditures per admission across hospitals, even after adjustment for case-mix and price differences. This proposal will create incentives for medical staffs to deliver services more efficiently. Savings for six years will be \$2.32 billion.

Medicare Parts A & B

The Health Security Act will achieve the following savings in both Parts A and B of the Medicare program.

- **Assure that OBRA 93 home health savings are retained.** OBRA 93 established a two year freeze on updates to the HHA limits. However a "catch-up" would occur when the HHA freeze expires on July 1, 1996. This proposal provides permanent savings by recalculating the percent of the mean that would produce the same amount of savings as if the freeze were continued. This proposal will result in a 6 year savings of \$2.42 billion.
- **Switch from mean to median costs when calculating home health agency cost limits** for cost reporting periods starting July 1, 1997. In the case of HHA costs limits, a few very high cost agencies can have the effect of raising everyone's limits. Moving to the median will produce limits that are more representative of typical HHA costs and encourage HHAs to achieve efficiencies. Six-year savings for this proposal will be \$650 million.
- **Establish a copayment for home health visits** at 10 percent of average cost per visit for all visits except those occurring within a 30 day period following an inpatient hospital discharge. HHA expenditures have increased tremendously over the past few years, almost doubling between fiscal year 1990 and fiscal year 1992. For fiscal year 1994, the projected increase is nearly 33 percent. This

proposal will provide Medicare beneficiaries with an incentive to reduce unnecessary utilization and seek the optimum amount of care. This proposal would be effective July 1, 1995 and savings over 6 years would be \$8.59 billion for this proposal.

- **Expand Centers of Excellence** by contracting with individual centers using a flat payment rate for all Medicare services associated with cataract or coronary artery bypass graft surgery. The Secretary would also be granted authority to designate other services that might be appropriate for this approach. Medicare beneficiaries would be encouraged to use these centers by providing a rebate to the beneficiary equal to 10 percent of the government's savings from the center. HCFA has initiated two bundled payment demonstration projects involving CABG and cataract surgery that show potential for Medicare savings. By expanding this concept, Medicare will be able to reduce expenditures by \$540 million over 6 years.
- **Permanently extend the Medicare secondary payer data match** (which OBRA 93 extended through fiscal year 1998) between HCFA, IRS and SSA to identify the primary payers for Medicare enrollees with health coverage in addition to Medicare. The program identifies situations where Medicare made a mistaken primary payment rather than the secondary payment required under the law for certain beneficiaries. This proposal would save \$525 million over 6 years.
- **Lower the Medicare secondary payor provision for the disabled from 100 to 20 employees.** For persons who are disabled, the current Medicare secondary payer provisions apply only if their employers have 100 or more employees. This relieves small employers of the financial burden of carrying health insurance with primary payer responsibility for disabled employees. This protection for small employers will become unnecessary under health care reform, which provides for universal coverage and standard premiums. This proposal will save \$650 million over 6 years. Under health care reform, small employers will no longer be vulnerable to paying higher premiums for covering disabled or other high-risk individuals because of community rating. A separate provision in the Health Security Act will require that all employer-based coverage provide primary coverage for those eligible for Medicare, including disabled workers.
- **Extend Medicare secondary payer provisions for the disabled.** Permanently extend the provision making Medicare the secondary payer for disabled employees with employer-based health insurance. Extending this provision would allow Medicare dollars to be spent on services for individuals who do not have employment related health insurance coverage. Six year savings would equal \$2.33 billion.
- **Extend Medicare secondary payer provisions for end-stage renal disease.** Permanently extend the provision requiring non-Medicare insurers to be the primary payer for ESRD patients for 18 months before Medicare becomes the primary payer. This provision would save \$180 million. As with the MSP provision related to the disabled, the enactment of community rating will protect employers from vulnerability to higher premiums related to coverage of high-risk individuals. A separate provision of the Health Security Act addressing Medicare workers, spouses of workers, and their dependents would eliminate the 18-month time limit on employer plan coverage of individuals with ESRD.
- **Apply a ceiling and floor to risk HMO payments.** Under the current risk payment methodology, there is tremendous variation in payments by county, particularly in the Part B portion of the AAPCC. While factors such as the mix of teaching and disproportionate share hospitals can help explain some of the variation, the impact of other factors such as utilization remains unclear. This proposal would establish more equitable payments across the nation and, as a result, force certain plans to better manage service utilization. Savings for this proposal would equal \$1.285 billion over 6 years.

New Revenue

The Health Security Act includes one Medicare proposal for new revenues.

- **Extend Hospital Insurance tax for State and local workers.** We propose to make the wages of employees of all State and local governments subject to the Medicare HI tax. About 20 percent of employees of State and local governments are exempt from the Medicare tax and often become entitled to Medicare based on short periods of covered work or a spouse's Medicare entitlement. These persons have not paid their fair share of taxes compared to most workers who pay into the HI Trust Fund throughout their working years. A study by the Inspector General found that 85 percent of the retirees of government agencies exempt from Medicare coverage are Medicare enrollees. The average contribution of these individuals was only 36 percent of the average for all Medicare beneficiaries. This proposal would raise \$7.309 billion over a 5 year period.

Conclusion

The President's Health Security Plan includes important Medicare proposals that reinforce the program while, at the same time, reduce its rate of growth. We believe these changes in the Medicare program are attainable and necessary for successful reform of the health care system as a whole. But the price of restructuring our health care system is a shared responsibility that will depend on the cooperation and contribution of physicians, hospitals, and other health care providers, as well as beneficiaries.

We do have the resources to meet the health care needs of all our citizens **if we spend our health dollars wisely**. With everyone's willingness to participate, we can afford universal coverage without compromising quality or limiting the availability of necessary health care services for the elderly population or any other population in our country.

I look forward to working with you in the months ahead to forge a consensus on health care reform that promotes the improved health status of our citizens and strengthens our national productivity.

MEDICARE UNDER HEALTH CARE REFORM

The Health Security Act proposes to slow the rate of growth of costs in the Medicare program, as well as to provide enhanced benefits to Medicare enrollees. The changes we propose will be within the framework of a thorough reorganization of the health care system in which everyone stands to gain.

- In the context of a plan that will bring down private sector costs, we can achieve Medicare savings without shifting costs to the private sector or endangering beneficiaries' access to services. The President's plan -- and virtually every Democratic and Republican health care plan that has been proposed -- recognizes that we can save money by lowering the rate of growth in Medicare and Medicaid.
- Our bill identifies \$124.4 billion in specific, scorable, line-by-line savings in the Medicare program. That's \$124.4 billion dollars to redirect in the interest of the health of all Americans and in the interest of the nation's economy.
- This amount is comparable to the savings proposed by the Senate Republican plan, and less than the savings called for by some single-payer proposals. And while the amount of our savings may seem high today, we must keep in mind they will be taken from a future base of \$1.2 trillion in projected Medicare spending over the years 1995 to 2000. What's more, the \$124.4 billion will only reduce the growth in Medicare spending from triple the inflation rate to double.
- A significant portion of the savings from these proposals are largely a result of eliminating or reducing payments to providers that were originally intended to ease the financial pressures created by uncompensated care. With universal coverage, virtually all care will be compensated.
- Lowering the rate of growth in Medicare program expenditures is perhaps the most important thing we can do for beneficiaries. Lower expenditures over time mean that beneficiaries pay less out-of-pocket in the form of coinsurance and deductibles. It also means that future Medicare beneficiaries can look forward to a stronger, more financially sound, Medicare program because reducing costs in both sectors of the economy will serve to improve the long-term integrity of the Medicare trust funds.

Medicare Savings under Health Care Reform
(\$ in millions, by FY)

	1994	1995	1996	1997	1998	1999	2000	Total 1994 - 2000
Part A								
Hospital Update at MB-2% in '97-2000	0	8	0	930	2,670	5,610	8,750	18,160 *
D/E (7% 1996, incr. by under-65 premiums)	0	0	2,470	3,110	3,470	4,130	4,660	17,840 *
Reduce Medicare Payments for Capital	0	0	995	1,400	2,005	2,610	3,215	10,325 *
Phase Down DSH as States Enter HCR System	0	0	430	1,230	2,670	4,390	4,810	14,630
Monetization on New LTC Hospitals	0	20	40	70	100	130	170	530 *
Extend OBRA 93 SNF Savings	0	0	80	160	180	200	210	830 *
GME (pay to AHCs, increased by CPT)	0	0	-30	-60	-150	-20	-20	-280 *
Part A Interactions	0	0	0	-110	-300	-810	-730	-1,650 *
Subtotal Part A	0	20	3,985	6,830	11,845	16,240	21,165	60,385
Part A Revenue Proposal								
State and Local Employees before 4/1/86	0	0	1,535	1,518	1,470	1,420	1,366	7,309 #
Part B								
Base MYPs on Real GDP Per Capita (Prim. Care=GDP+1.5%)	0	0	0	275	1,075	1,975	2,775	6,100 *
Set Cumulative Physician Expenditure Goals	0	0	0	-85	1,825	2,475	1,600	5,815 *
Reduce CF by 3% in 1996, Except Primary Care	0	250	475	525	580	575	600	2,975 *
Eliminate Formula-Driven Overpayment in								
Hospital C/Ds	150	1050	1,300	1,690	2,190	2,750	3,480	12,610 *
Competitively Bid for Medicare Labs	0	140	220	260	290	320	340	1,590
Competitively Bid for Part B Services	0	110	190	210	240	270	300	1,320
Increase Related Premium (\$90K/\$115K, \$15 K phase-in)	0	0	350	950	900	1,060	1,200	4,490 ##
Interaction	0	0	0	-15	-30	-75	-130	-250
Reestablish Lab Coinsurance (20%)	0	680	1,070	1,230	1,380	1,540	1,720	7,590 *
Part B Premiums	0	0	0	0	0	1,770	4,310	6,080 *
Interaction	0	0	-710	-1,090	-2,140	-2,770	-3,180	-9,890 *
High Priced Medical Staffs	0	0	0	0	500	780	1,040	2,320 *
Prohibition on balance billing	0	0	-130	-250	-260	-270	-290	-1,200 *
Subtotal, Part B	150	2,200	2,765	3,700	6,850	10,400	13,785	39,350
Part A & B								
Extend OBRA 93 Home Health Savings	0	0	0	480	600	680	690	2,420 *
Home Health Limits: 100% Median	0	0	0	10	160	290	250	650 *
10% HHA Costs, (after 30 days post-discharge)	0	230	1,400	1,560	1,680	1,800	1,920	8,590 *
Expand Centers of Excellence								
Part A	0	0	60	70	70	70	70	340
Part B	0	0	40	40	40	40	40	200
Extend Medicare Secondary Payer (MSP) Data Match	0	0	0	0	0	195	330	525 *
MSP Disabled: change threshold from 100 to 20, 1/1/98	0	0	0	0	150	240	260	650 *
Extend OBRA 93 Provision on MSP for Disabled	0	0	0	0	0	990	1,340	2,330 *
Extend OBRA 93 MSP ESRD Provision	0	0	0	0	0	75	108	180 *
HMO Payment Improvement	0	30	90	165	250	350	400	1,285 *
Subtotal Part A & B	0	260	1,590	2,325	2,980	4,440	5,408	17,170
SAVINGS, TOTAL PACKAGE								
	150	2,460	9,875	14,373	22,815	33,000	41,721	124,414

* indicates OACT pricing.

indicates net Treasury pricing.

includes Treasury estimates of changes in income and OACT estimates of reduced outlays for those who drop Part B coverage.

November 17, 1993

MEDICARE SAVINGS PROPOSALS for HEALTH REFORM
(\$ in millions)

PART A PROPOSALS

Reduce the Hospital Market Basket Index (HMBI) Update by 2% in FY 1997-2000. Medicare changes the inpatient per-discharge standardized amount by a certain amount every year to reflect input cost changes and Congressional direction. OBRA 93 reduced the HMBI in FYs 94 - 97 by 2.5, 2.5, 2, and 0.5 percentage points respectively, to reflect greater efficiencies in hospitals. This proposal would reduce the market basket updates by 2% for FY 1997 - FY 2000. Since the market basket is projected to increase 5% annually, and case mix is projected to increase 2% per year, hospitals can still expect an overall 5% increase per year.

Savings

	1996	1997	1998	1999	2000	1996 - 2000
	\$0	930	2,870	5,610	8,750	\$18,160

Reduce Indirect Medical Education (IME) Adjustment to 3.0% in FY 1996. A portion of the IME is intended to compensate hospitals for uncompensated care. Universal coverage, however, will ensure payment for all patients and essentially eliminate uncompensated care. In 1996, the IME adjustment will be lowered to 3.0% under this proposal. Beginning in FY 1997, the aggregate amount of IME payments will be increased by the projected national average increase in premiums for the under-65 population for those States that opt into the reformed system; by 1998, all Medicare IME payments will be made in this fashion. These payments will be appropriated to a national pool to finance the higher costs of academic health centers. The cash flow effect for IME payments is built into these estimates.

Savings

	1996	1997	1998	1999	2000	1996 - 2000
	\$2,470	3,110	3,470	4,130	4,660	\$17,840

Adjust Inpatient Capital Payments to Reflect Better Cost Data. This proposal combines three inpatient capital payment adjustments to reflect more accurate base year data and cost projections. The first piece would reduce inpatient capital payments to hospitals excluded from Medicare's prospective payment system (PPS) by 15% for FY 1996 - 2000. PPS-excluded hospitals, currently paid at full costs, do not have an incentive for efficiency. The second piece would reduce PPS Federal capital payments by 7.31 percent and hospital-specific amount by 10.41 percent to reflect new data on the FY 1989 capital cost per discharge and the increase in Medicare inpatient costs from FY 1990 to FY 1992. The last piece would reduce payments for hospital inpatient capital through a 22.1% reduction to the FY 1996 - 2000 updates of the capital rates. Current data indicate that Medicare inpatient capital cost per discharge increased 77.5% during the years immediately before the introduction of prospective payment for capital-related costs (FY 1986 - FY 1991). The identifiable variables for capital costs only increased 38.2% over the same period. This proposal would reduce the update to the capital rates by 4.9% each year during FY 1996-2000 to recover excess capital spending.

Savings

1996 \$995	1997 1,400	1998 2,005	1999 2,610	2000 3,315	1996 - 2000 \$10,325
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Revise the Disproportionate Share Hospital (DSH) Adjustment. Hospitals that treat a disproportionate share of low-income patients receive an additional payment. Studies show that the additional payment overcompensates for the higher costs associated with treating low-income Medicare patients. In the reformed system with universal coverage, DSH can be reduced. This proposal would replace the current DSH program with a new program as States come into the new system. The new program would assist hospitals serving the largest share of low-income patients.

Savings

1996 \$430	1997 1,330	1998 3,670	1999 4,390	2000 4,810	1996 - 2000 \$14,630
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Moratorium on PPS-Exempt Long-Term Care Hospitals. Long-term care hospitals, which have an average length of stay of over 25 days, are currently exempt from the PPS system, receiving cost-based reimbursement from Medicare, subject to a rate-of-increase limit. This proposal would pay new long-term care hospitals under the PPS system. Alternatively, these hospitals could seek reclassification as psychiatric or rehabilitation hospitals, or become certified as skilled nursing facilities (SNFs), for example, and be paid under the SNF cost limit structure.

Savings

1995	1996	1997	1998	1999	2000	1995 - 2000
\$20	40	70	100	130	170	\$530

Extend OBRA 93 Provision: Eliminate Catch-Up after SNF Freeze Expires. OBRA 93 established a two-year freeze on updates to the cost limits for skilled nursing facilities (SNFs). A "catch-up," however, is allowed after the SNF freeze expires on October 1, 1995; new cost limits would be established that do not reflect the effects of the freeze. This proposal would eliminate the "catch-up" by recalculating the percent of the mean that would serve as the cost limit. The recalculation would be calibrated to result in the same amount of savings as a continuation of the freeze.

Savings

1996	1997	1998	1999	2000	1996 - 2000
\$80	160	180	200	210	\$830

Graduate Medical Education: Effect of National Pool. Under the legislation, Medicare would pay into two national pools: one for direct medical education, and one for academic health centers. The projected Medicare spending for direct and indirect medical education would be transferred to the Secretary for those States that have opted into the reformed system; by 1998, all States will be folded into the new system. These funds will be transferred out of the Trust Funds faster than they are currently paid to hospitals. This will result in a slight cost to Medicare. The costs displayed here are the cash flow effect for direct graduate medical education.

	<u>Costs</u>			
	<u>1996</u>	<u>1997</u>	<u>1998</u>	<u>1999</u>
	(\$30)	(60)	(150)	(20)
				<u>2000</u>
				(20)
				<u>1996 - 2000</u>
				(\$280)
<u>Interaction Costs</u>				
		(110)	(300)	(510)
				(730)
				<u>(\$1,650)</u>
PART A	(\$0)			
INTERACTION				

PART A REVENUE PROPOSAL

Subject All State and Local Employees to Hospital Insurance Tax. State and local jurisdictions can opt to pay the HI payroll tax for State and local workers hired before April 1, 1986, but are not required to do so. The proposal would extend the payroll tax to all remaining exempt State and local workers, who would thus be treated like all other covered workers. Additional revenues would exceed benefit payments for a long time, since 90% of retired State and local workers already receive Medicare benefits through other covered jobs or spousal employment; only about 70%, however, worked in State or local government jobs on which HI taxes were paid.

Savings				
	1996	1997	1998	1999
	\$1,535	1,518	1,470	1,420
				2000
				1,366
				1996-2000
				\$7,309

(Estimates for this proposal were calculated by Treasury Department staff.)

Base MVPS on Real GDP Per Capita. This proposal would change the statutory formula that is used to determine the Medicare Volume Performance Standard (MVPS), a target for the rate of growth in Medicare physician expenditures. Currently, the MVPS is based on the average annual growth in the volume and intensity of physicians' services over the preceding five fiscal years. This proposal would substitute the five-year average of growth in real GDP per capita for this volume and intensity factor and the performance standard factor. This change would directly connect the MVPS to the growth rate of the nation's economy. The MVPS for all three categories of physician services (surgical, primary care, and all other) would continue to be adjusted for projected increases in physicians' fees, beneficiary enrollment, and changes resulting from regulatory and legislative activity. The MVPS for primary care services would be given an additional 1-1/2 percentage point upward adjustment. Under current law, there is no upper limit on physician fee increases, but fees cannot decrease by more than five percentage points. This proposal would eliminate the floor on physician fee reductions.

Savings				
1996	1997	1998	1999	2000
\$0	275	1,075	1,975	2,775
				<u>1996-2000</u>
				\$6,100

Establish Cumulative Growth Targets for Physician Services. Currently, the MVPS for each year is based on the prior year's actual rate of growth in outlays, without regard to the prior year's target rate of growth in outlays. This process weakens the ability of the MVPS to serve as a meaningful target for sustainable growth in Medicare physician spending. Under this proposal, the MVPS for each category of physician services would be built upon a designated base-year MVPS (FY 1995). This initial target would be updated annually for changes in beneficiary enrollment and inflation, but not for actual outlay growth above or below the target. Essentially, physician fee changes in any one year would no longer distort the MVPS for the following years. The annual process for calculating physician fee updates would not change from current law.

Savings				
1996	1997	1998	1999	2000
\$0	(85)	1,825	2,475	1,600
				<u>1996-2000</u>
				\$5,815

Reduce the Medicare Fee Schedule Conversion Factor by 3% in 1995, Except Primary Care Services. The conversion factor is a dollar amount that converts the fee schedule's relative value units (RVUs) into a payment amount for each physician service. This proposal would reduce the conversion factor by 3% in CY 1995 to account for the excessively high FY 1992 target and 1994 update that is anticipated, except that primary care services would not be reduced.

Savings					
1995	1996	1997	1998	1999	2000
\$250	475	525	550	575	600
					1995-2000
					\$2,975

Eliminate Formula-Driven Overpayment in Hospital Outpatient Departments. Under current law, Medicare pays for hospital outpatient ambulatory surgery, radiology, and other diagnostic services using a blended payment methodology. Because of a flaw in the statutory payment formula, which assumes a lower coinsurance payment than is actually made, hospitals receive more than the intended payment amount. This proposal would eliminate the flaw in the payment methodology and the resulting overpayment, effective July 1, 1994. In addition, the current payment method gives hospitals strong incentives to increase charges for these services, thus raising beneficiary coinsurance liabilities. Fixing the formula-driven overpayment would mitigate the hospital incentive to raise the charges to Medicare enrollees.

Savings					
1994	1995	1996	1997	1998	1999
\$150	1,050	1,300	1,690	2,190	2,750
					2000
					3,480
					1994 - 2000
					\$12,610

Contract Competitively for All Part B Laboratory Services. The Secretary would be required to establish the same kind of competitive acquisition system for Medicare laboratory services as for other selected Part B items and services beginning January 1, 1995. Pricing assumes that competitive contracting will reduce the price of laboratory services by 10%. Medicare laboratory payments currently are projected to grow by 15% to 18% per year. This proposal seeks to curtail the growth rate by lowering the price of tests and reducing the profit incentive for physicians to order unnecessary tests. If the competitive system does not result in a reduction of at least 10 percent in the price of all laboratory services from the price that would otherwise occur in 1996, then the Secretary would reduce Medicare fees for these selected services to achieve an overall 10 percent reduction in price.

Savings					
1995	1996	1997	1998	1999	2000
\$140	220	260	290	320	360
					1995 - 2000
					\$1,590

Competitively Bid Selected Medicare Part B Items and Services. This proposal would require the HHS Secretary to contract competitively for Medicare services and supplies, based on quality and other standards. The initially planned items for competitive procurement are MRIs, CAT scans, oxygen services, and enteral nutrients. Pricing assumes a 10% reduction in price for these services and supplies. If the competitive system does not result in a reduction of at least 10 percent in the price of these selected services from the price that would otherwise occur in 1996, then the Secretary would reduce Medicare fees for these selected services to achieve an overall 10 percent reduction in price.

Savings

1995	1996	1997	1998	1999	2000	1995-2000
\$110	190	210	240	270	300	\$1,320

Income-Related Part B Premium. Fully Phased-in to 75%. Currently, all Medicare enrollees pay the same Part B premium, regardless of income. This premium is set at approximately 25% of program costs, beginning in 1996; the balance is paid by general revenues. This proposal would charge high-income enrollees a premium up to 75% of program costs. The increase in the premium for single individuals would begin at modified adjusted gross incomes (plus taxable Social Security benefits) of \$90,000 and phase up to 75% for those individuals with incomes equal to or above \$105,000. The increase for couples would begin at \$115,000, with the maximum 75% premium being paid by couples in which both are eligible for Medicare with a combined income of over \$130,000.

Savings (includes Interaction)

1996	1997	1998	1999	2000	1996-2000
\$350	935	900	985	1,070	\$4,240

Re-establish 20% Coinsurance for Laboratory Services. This proposal would re-establish a 20% coinsurance on all physician office, outpatient, and independent laboratory tests under Medicare Part B, effective January 1, 1995. Congress eliminated the required coinsurance on laboratory services for independent labs and those in hospital outpatient departments in 1984. In 1985, Congress eliminated the coinsurance for physician office laboratory services. Clinical laboratory services are the only services provided under Medicare Part B for which no coinsurance is now required.

Savings

1995	1996	1997	1998	1999	2000	1995-2000
\$650	1,070	1,230	1,380	1,540	1,720	\$7,590

Extend OBRA 93 Provision: 25% SMI Premium through 2000. OBRA 93 established the Part B premium collections at 25% of program costs for 1996-1998. This proposal would extend the OBRA 93 provision requiring that Part B premium collections cover an estimated 25% of program costs.

	Savings				
	1996	1997	1998	1999	2000
	\$0	0	0	1,770	4,310
					\$6,080
Interaction	(\$710)	(1,090)	(2,140)	(2,770)	(3,180)
					(\$9,890)
NET	(\$710)	(1,090)	(2,140)	(1,000)	1,130
					(\$3,810)

Limit Payments to High-Cost Medical Staffs. This proposal would establish limits on Medicare physician payments per inpatient hospital admission, similar to limits used in other parts of Medicare. The proposal would take effect in 1998. Payment limits would be established based on the median of hospital-specific case-mix adjusted relative value units per admission. For urban hospitals, the limit would be 125% of the national median in 1998 and 1999, and 120% in 2000 and thereafter. For rural hospitals, the limit would be 140% of the national median in 1998 and thereafter. Annually, a hospital-specific per admission relative value would be projected for the upcoming year for each hospital. This projection would be adjusted for each hospital's teaching status and disproportionate share. At the beginning of each year, Medicare would establish a 15% withhold for medical staffs projected to be over the national limit. After the end of each year, Medicare would compare the actual RVUs per admission per hospital to the limit for that year. For medical staffs above the limit, either none or only a portion of the withhold would be returned. For medical staffs below the limit, the entire withhold would be returned.

	Savings				
	1995	1996	1997	1998	1999
	\$0	0	0	500	780
					1,040
					\$2,320
1996 - 2000					

Prohibition on Balance Billing. Physicians and other providers of Part B services are said to “accept assignment” on Medicare claims when they accept the Medicare approved amount as payment in full for covered services. Balance-billing (also called extra-billing) occurs when providers charge more than the Medicare approved amount – Medicare pays 80% of the approved amount and the beneficiary or other payor (e.g., Medigap insurance) is responsible for paying the balance. Balance-billing is prohibited under current law for most Part A and B services. Physicians may not charge more than 15% over the Medicare approved amount for their services, and only about 6% of all physician dollars are billed on an unassigned basis. Elimination of balance-billing remaining in Medicare will make for consistent treatment of all services within Medicare and between Medicare and the health alliance-approved plans serving the under-65 population. It will also reduce beneficiary confusion, enhance beneficiaries’ financial protection, and simplify carrier administration. This proposal will mandate assignment and prohibit all balance-billing by providers of Part B services effective January 1, 1996. The costs from this proposal arise largely from elimination of the participating physician payment differential.

<u>Costs</u>				
1996	1997	1998	1999	1996-2000
(\$130)	(250)	(260)	(270)	(\$1,200)
			2000	
			(290)	

PARTS A AND B PROPOSALS

Extend OBRA 93 Provision: Eliminate Catch-Up after Home Health Freeze Expires. OBRA 93 eliminated the inflation adjustment to the home health limits for two years, FY 1994-1995. This proposal would eliminate the inflation "catch-up" - currently allowed after the freeze expires on July 1, 1996 - by recalculating the percent of the mean that would produce the same amount of savings as if the freeze continued. HCFA actuaries estimate this to be 100% of the mean.

Savings

1996	1997	1998	1999	2000	1996 - 2000
\$0	480	600	650	690	\$2,420

Lower Home Health Limits to 100% of Median. Home health is projected to rise over 10% a year through 1998, including 33% growth in 1994. This proposal would lower the cost limits to 100% of the median for cost reporting periods beginning on or after July 1, 1997. In other words, Medicare would reimburse home health agencies at a rate no higher than the costs encountered by half of the agencies.

Savings

1996	1997	1998	1999	2000	1996 - 2000
\$0	10	160	230	250	\$650

Require a 10% Copayment on All Home Health Visits for Visits other than Those Occurring 30 Days after a Hospital Discharge. Home health is one of the fastest growing benefits in Medicare, with a projected increase in home health outlays of nearly 33% in 1994. Medicare enrollees do not currently pay cost-sharing on home health care. This provision would charge a copayment on all home health visits except those received within 30 days of an inpatient hospital discharge; these visits are less discretionary and more intensively rehabilitative. Enrollees who receive home health without an inpatient stay would pay the 10% copayment on all services. The copayment would be equal to 10% of the average cost per visit.

Savings

1995	1996	1997	1998	1999	2000	1995 - 2000
\$230	1,400	1,560	1,680	1,800	1,920	\$8,590

Expand Centers of Excellence. HCFA has initiated two bundled payment demonstration projects that show potential for Medicare savings. These projects involve contracting with "Centers of Excellence" that perform coronary artery bypass graft (CABG) surgery and cataract surgery. By expanding this concept to all urban areas, contracting with individual centers using a flat payment rate for all services associated with the cataract or CABG surgery, Medicare would be able to reduce costs. The Secretary also would be granted the authority to designate other services that lend themselves to this approach. Beneficiaries would not be required to receive services at these centers, but would be encouraged to do so through rebates representing 10% of the government's savings from the center. Pricing assumes a 10% discount in the price of services for the 20 percent of beneficiaries who are assumed to use the centers.

	1996	1997	1998	1999	2000	1996 - 2000
	\$60	70	70	70	70	\$340
<i>Part A</i>						
<i>Part B</i>	\$40	40	40	40	40	\$200

Extend OBRA 93 Provision: Medicare Secondary Payer (MSP) Data Match with SSA and IRS. OBRA 93 included an extension of the data match between HCEA, IRS, and the Social Security Administration to identify the primary payors for Medicare enrollees with health coverage in addition to Medicare. This proposal would extend that provision beyond its scheduled expiration date of 1998.

	1996	1997	1998	1999	2000	1996 - 2000
Savings	\$0	0	0	195	330	\$525

Establish a Threshold of 20 Employees for MSP for the Disabled. OBRA 93 extended through 1998 an OBRA 90 provision making Medicare the secondary payor for disabled enrollees with employer-based health insurance. The provision is applicable to all employers with 100 or more employees. This proposal would lower the employee threshold from 100 to 20 employees beginning on January 1, 1998. With community rating under health care reform, small employers will no longer be vulnerable to paying higher premiums for covering disabled or other high-risk individuals. A separate provision in the Health Security Act addressing alliance enrollment of Medicare beneficiaries who work or whose spouses work would eliminate the employee threshold. The provision would require all employer-sponsored plans to cover workers, dependents of workers and workers' spouses who are eligible for Medicare.

Savings				
1996	1997	1998	1999	1996 - 2000
\$0	0	150	240	260
				\$650

Extend OBRA 93 Provision: MSP for Disabled. OBRA 93 extended through 1998 an OBRA 90 provision making Medicare the secondary payor for disabled beneficiaries with employer-based health insurance. This proposal would extend this provision permanently.

Savings				
1996	1997	1998	1999	1996 - 2000
\$0	0	0	990	1,340
				\$2,330

Extend OBRA 93 Provision: Medicare Secondary Payor Provisions for ESRD Patients. OBRA 93 extended through FY 1998 a provision that makes Medicare the secondary payor for individuals with end stage renal disease (ESRD) enrolled in employer group health plans for 18 months after they become eligible for Medicare benefits. This provision permanently extends the MSP provision for individuals with ESRD. A separate provision in the Health Security Act addressing alliance enrollment of Medicare beneficiaries who work or whose spouses work would provide for coverage of individuals with end stage renal disease for as long as the individual requires care. The provision would require all employer-sponsored plans to cover workers, dependents of workers and workers' spouses who are eligible for Medicare.

Savings				
1996	1997	1998	1999	1996 - 2000
\$0	0	0	75	105
				\$180

HMO Payment Improvement. Medicare pays 95% of the average adjusted per capita cost (AAPCC) for Medicare enrollees in Medicare-contracted HMOs. This proposal would establish a range around the Part A and Part B components of the AAPCC that would presumably encourage HMOs to participate in Medicare while establishing reasonable limits on reimbursement for high-cost counties. The ceiling would be 150% of the national average Part B component of the AAPCC and 170% for the Part A component of the AAPCC, with a floor established at 80%. The range would be phased-in over a four-year period, beginning in 1995.

Savings

1995	1996	1997	1998	1999	2000	1995 - 2000
\$30	90	165	250	350	400	\$1,285

TOTAL SAVINGS

1994	1995	1996	1997	1998	1999	2000	1994-2000
\$150	2,480	9,875	14,373	22,815	33,000	41,721	\$124,414

Chairman STARK. Well, let me just focus—because we will go around here 5 minutes at a crack just to get you warmed up. I am concerned, and you can respond, that these cuts will interfere with Medicare access, and I am going to ask you to respond in the unlikely event that the premium caps or some other, say, competition or very loosely structured controls on the private side don't work, and with Medicare already paying about 70 percent of private pay, is there any reason to think that there will not begin to be some access problems in Medicare? That is one.

Then I am going to grill you a little bit on your knowledge of SSI and how people qualify for that and how you will completely disrupt the payments to disproportionate share hospitals, understanding that disproportionate share has been a formula in legislation for paying certain hospitals, primarily in inner cities, extra money under a DRG program.

The other side of the coin is we have negotiated with our brothers and sisters who represent rural districts by paying some more to rural areas, and we have come to a political equilibrium. If you understand SSI, you will understand that there are far more folks who qualify in poor southern States, that HCFA has done a lousy job of outreach, far fewer people who qualify for SSI are on it than as a percentage of Medicaid, and the Department of Health and Human Services has repeatedly turned away from qualifying—I think the last attempt was to put out comic books.

So we are going to talk a little bit about that. We are going to talk a little bit about the capital restructuring, and then I want to talk about where the department is in terms of getting us the information we need and getting a program going for outpatient services.

A 20 percent yearly annual increase is unacceptable. Our beneficiaries are paying coinsurance that amounts to 35 percent. We have been asking for some time for a prospective payment system for outpatient services. There is no reason that radiology and ambulatory surgical services couldn't be put into effect very quickly. That saves—and we could spend some of this savings to help the beneficiaries rather than allow greedy hospitals and doctors to gouge them, most of whom are relatively poor.

There is also this question in the bill of people being locked in, as you just so blithely skipped over, into an HMO when the evidence is in in Florida, and there is an article here from the Sun Sentinel, and we will get to that, people are being misled and abused by abusive sales practices, mostly by Humana and other such groups, and there is a statement, although it is an anonymous official quoted as saying that nothing is really being done to check on the quality of these HMOs and marketing in Florida.

So we will go through a number of those today, and see whether you can increase our confidence level that we can in fact depend on HCFA to take care of its present program before we let Magaziner, Zelman and Starr ruin a perfectly good system.

So why don't you start with the private payers and the issue of how we are going to deal with outpatient care in the near term, and then we will get on to these questions on my next several rounds.

Mr. VLADECK. On the outpatient question, should I begin with that, sir?

Chairman STARK. Yes, why don't we start with that.

Mr. VLADECK. We are significantly overdue with a report to the Congress on recommendations for a prospective payment system for outpatient services. Most of that delay, of course, occurred in the prior administration. We are very close to being in a position to release that report to you. I won't promise it by the end of the calendar year, but certainly in plenty of time to take legislative action relative to recommendations next year. We will have a report and recommendations on an outpatient payment system.

Chairman STARK. For which we will resoundingly applaud the new direction in HCFA.

Mr. VLADECK. In that case, I will personally present it.

Chairman STARK. OK. I will turn you over to Mr. Thomas now.

Mr. THOMAS. Thank you, Mr. Chairman. We will obviously go through several rounds.

I would rather just start at the beginning and ask you some general questions to set the stage as we go through, because all of us are, I believe, pretty obviously dedicated to trying to do something in this area.

My concern is that we have realistic goals, realistic targets, and we go about them in realistic ways. To the degree we do not posit that, my argument is that we tip over into the political side of it rather than the solution side.

Full well understanding who you are and who you represent, I would still nevertheless appreciate, as I don't want to say honest, but as good an answer you can give given the constraints of who you are and where you are coming from in terms of these kinds of questions. We are into this on the basis of the health care costs of the United States going up at a percentage that is unacceptable. OK. If we compare ourselves with many of the other nations that we like to compare ourselves with in terms of standard of living and profiles, our costs are slightly higher. The Clinton plan however, when it is fully implemented, is expecting us to then function at a yearly percentage of costs significantly lower than the others.

Is that, in part, an overstatement of one where we should go, where we need to go, and perhaps, a bit political? Are you comfortable with the crash pattern of the numbers as structured under the plan? I don't know how free you are to discuss this.

Mr. VLADECK. Well, let me try if I can. Clearly, the targets laid out in the plan for reduction in—

Mr. THOMAS. I understand that. The First Lady came before us and everybody else who came before us said the numbers are scrubbed, the numbers fit. It is given that the numbers fit.

The question is, are they achievable? I have no doubt that if X is accomplished, Y will occur. The question is, is it politically reasonable or even financially reasonable in the structure we are dealing with to say that those are the kinds of numbers that we can produce?

Mr. VLADECK. The answer is, of course, we don't know. But I would be happy to make the argument that, at this stage in the process, it makes sense from a variety of perspectives to set a very ambitious target and a very ambitious objective. I think as the re-

form plan is envisioned and particularly as it goes out past the year 2000 budget window, we are proposing a very rapid deceleration in the last years of this decade to permit a plateauing in the next decade at a level closer to that achieved elsewhere in the world.

The question is really—

Mr. THOMAS. I understand all those. We have heard all those. We are all going to put our nose to the grind stone and all of that. My question is, can you honestly and comfortably as a professional, in looking at the tough targets that you have structured, argue successfully that we aren't going to sacrifice some quality in the beneficiary services given that kind of a reduction which we have never had before?

Mr. VLADECK. Again, we don't know for a fact. I would say that—

Mr. THOMAS. But, see, my argument is that I do know for a fact. You have got to convince me that we aren't going to hurt the quality of beneficiary services with that kind of a number reduction. I am convinced we are. Your job is to convince me we are not.

Mr. VLADECK. Well, we are talking about a very significant reorganization of the system which has at least two components to it, I think. One is—on the private side, these very significant onetime savings that we will achieve that do wonders for the overall rate of growth that come about through consolidation of the small group insurance market. And some of the other administrative steps we estimate will create a onetime savings spread over several years in the range of \$30 to \$50 billion, a significant amount of money, and then lowers the base from which to go forward.

The other question is the extent to which people—providers really—move themselves into a world in which they are operating under what are effectively capitated budgets, and the extent to which they can reorganize themselves to operate in such an environment. Some already are. For others, it will occur in a relatively short period of time.

We believe that over a long period of time it is possible to live within those budgets, and in fact improve quality. The question is how quickly can people learn to do that. I think I can't ever convince you that there is a high likelihood they will do it without hurting quality, but I think we have some experiences that suggest that at least it is reasonably possible to expect that they could.

Mr. THOMAS. My time on this round has expired. It sounds to me like you were about ready to launch into that old Reagan joke about the room full of horse manure and the optimist and the pessimist in terms of moving in. No question you are the optimist in looking for the pony in there. We will get into some specifics as we move along. Thank you, Mr. Chairman.

Chairman STARK. Mr. McDermott.

Mr. McDERMOTT. Thank you, Mr. Chairman.

Good morning. How are you?

Mr. VLADECK. Very well.

Mr. McDERMOTT. Nice to be back with us, isn't it?

Mr. VLADECK. Always.

Mr. McDERMOTT. Long questions, short answers. My question comes as a physician looking at this whole plan and trying to read

the last edition that arrived up here on the Hill. It is my understanding that the quality provisions have been revised for Medicare so that the peer review ends before any other quality mechanism is put in place, and I have a real hard time understanding the thinking behind that.

In our bill, we put in a transition to case profiling away from peer review, but I can't understand why you would end peer review, have no quality judgment mechanism at all, and just sort of leave the system out there hanging. It doesn't sound like a very responsible way to deal with the quality of Medicare. Can you comment on that?

Mr. VLADECK. I will try, sir. I think that fell between the cracks in the various rounds of drafting.

Mr. McDERMOTT. Quality fell between the cracks?

Mr. VLADECK. Well, the issue of the transition from the Medicare program, between the existing program and something consistent with national quality standards and a role for the National Board and State and regional quality assurance mechanisms. I think the issue of the mechanics of the Medicare transition got lost in some of the redrafting, and we will need to work with you to fix that.

Mr. McDERMOTT. I think we have a section in H.R. 1200 that will fix it.

Mr. VLADECK. We will see if we can borrow it, if you will let us.

Mr. McDERMOTT. Let me ask another question, and this is a more fundamental question. When this bill was drafted, was the intention to get rid of Medicare from the very outset as quickly as possible?

Mr. VLADECK. No, sir. I think it is fair to say that there are some folks who participated in the process who would just as soon get rid of Medicare, but I think the intent of the President and of the policy is very clearly to maintain and strengthen the Medicare program.

The difficulty we have over time is twofold, and it is why the future of the Medicare program hinges so critically on the rest of the program. That is to say, on the one hand, even if we did everything we could to preserve the Medicare program as it now stands, or as it now stands with a drug benefit added, unless something happens on the cost side, the financial base of the program is unstable in the long term. And, as you know, I feel very strongly that we can't do very much more on the cost side unless there is effective cost containment on the private sector side.

On the other side of the equation, it is true that even with the addition of the drug benefit and a separate long-term care program, the Medicare benefit is still not comparable to that in the comprehensive benefit package.

Mr. McDERMOTT. You mean it is below?

Mr. VLADECK. It is less generous. There is still a big leap to equalize the benefits which would be a precondition for any real integration of Medicare into the rest of the system.

The only way to get to the point where you really can integrate the benefits is to reduce the rate of growth in the Medicare program so it is on a sound financial base, and to reduce the rate of growth in the private sector even more so that at some point you have the resources to equalize the two sets of benefits.

Mr. McDERMOTT. Can I ask a question—I mean, they had to make some assumptions when they were putting these figures together, which the chairman suggests we will go into a little bit deeper, but I want to look for the first assumption, that is, when do you expect that all citizens, all senior citizens will be out of Medicare and into the State health alliances?

Mr. VLADECK. That is way beyond any of the numbers we have looked at or any of the projections we have made. I don't think it will happen in our lifetimes, frankly, but—

Mr. McDERMOTT. Are you saying that because you think that some States will never have their program up and running to the point where they ask to fold in the Medicare people?

Mr. VLADECK. I think some States will continue for both policy and political reasons not to seek to integrate the Medicare program into theirs, yes, sir.

Mr. McDERMOTT. What is there in the financing of this system that would encourage a State to leave the senior citizens out?

Mr. VLADECK. I think some of the States will feel they have their hands full from a political as well as an operational point of view in managing their responsibilities for the other 85 percent of the population and will be just as happy to leave the Federal Government with the problems and the headaches associated with the Medicare program.

I think there is additional financial risk for the States in integrating of the Medicare program; there are additional operational responsibilities.

Mr. McDERMOTT. Wait a minute. Let me stop you right there. What is the additional financial risk to a State if the Federal Government is paying for them?

Mr. VLADECK. The requirements for integration with the States hold the Federal Government harmless in terms of its level of payment and hold the beneficiaries harmless in terms of the benefits. If the State messes up in some regard, the State is liable to keep the beneficiaries whole on the benefit side.

Mr. McDERMOTT. And so because senior citizens tend to use more health care then they would be an unstable cost center and more likely to drive them over the edge; is that what you are contending?

Mr. VLADECK. Again, the issue is not the absolute level of their expenditures, but the predictably and the stability of that, and the State again is at risk if there is a very substantial increase in Medicare costs under the integrated program.

Mr. McDERMOTT. But there was no end point at which they figured that everybody would be in the program?

Mr. VLADECK. No.

Mr. McDERMOTT. I will come back on another round. Thank you, Mr. Chairman.

Chairman STARK. Bruce, a moment ago you mentioned the instability of Medicare's long-term financial situation. Are you aware of any time in the last 10 years when Medicare was any more or less unstable than it is today?

Mr. VLADECK. No. I believe that the HI trust fund is probably in as good a shape today as it has been over the past decade.

Chairman STARK. Right. And is it not correct that Mrs. Clinton mistakenly or I think inappropriately always quotes the demise of the Medicare trust fund based on base line projections which the harbingers of doom have used for the last 10 years, saying if we follow these projections, which we never have, it would go broke, stipulating that if you follow the actual expenditures, after this committee and the Senate Finance Committee have reduced from base line every year, is it not the fact that Medicare is stable into certainly the first decade of the next century, and if in fact we had passed Stark-Gephardt, with a modest reduction, I think all you need is a 2 percent reduction in growth, Medicare is permanently stable? Aren't those figures about correct?

Mr. VLADECK. Well, I am not sure post OBRA 1993 what the exact figures will be in long-term stability, but the fact is you still need to achieve some significant compounded reductions from our base line in order to—

Chairman STARK. What I am saying is that something in the order of magnitude of a 2 percent a year reduction in the growth rate would stabilize the Medicare system for all time?

Mr. VLADECK. Something more than that; more on the order of 5 percent.

Chairman STARK. So we are close to having a system that is not only the best, most efficient, most popular system, but within a couple of points of the growth rate of being completely sound financially; isn't that a fair statement?

Mr. VLADECK. I think that is fair, and that the number over the 1996 to 2000 window, would be in the order of about \$100 billion.

Chairman STARK. Oh, yes, I could tell you that exactly. That is a CBO number, not a scrubbed, sanitized number from wonks, but indeed a number on which we can bet the congressional store, at least.

You missed one other opportunity, I think. It is conceivable, as you have indicated, that because the benefits on the private side are more generous than Medicare we would have some problem. If, in fact, we did not raise the benefits quite so high on the private side and allowed individuals or companies and unions to bargain for supplemental care but left the guaranteed benefits closer for the above poverty folks to the Medicare benefits, we would save a lot of money that way, isn't that the fact, so there is that alternative?

Mr. VLADECK. That is right, although once you add the drug benefit in the Medicare program, the biggest difference in terms of coverage between Medicare and the comprehensive benefit package is the absence of a cap on out-of-pocket expenses.

Chairman STARK. And the deductibles and copays which are far higher than they are—

Mr. VLADECK. But the big dollar ticket actuarially is the absence of a cap. Now the absence of a cap is much more expensive in an elderly population than it is in a younger population.

Chairman STARK. Absolutely. We went through that a few years ago, if you might recall. What I am suggesting, however, is that by adjusting the private side program, there is that alternative. It is in your notes, but you didn't—

Mr. VLADECK. I guess what I was responding to is that the savings from reducing the private comprehensive benefit package, par-

ticularly in terms of the cap, are nearly the order of magnitude of bringing Medicare up to the private package because of the very different implications of a cap for the elderly as opposed to the nonelderly.

Chairman STARK. There is a lot of bells and whistles in this plan which require working beneficiaries and beneficiaries whose spouses work to be covered under alliance health plans. Even after the beneficiary terminates the employment, you said they are going to have to be stuck in these plans for a year.

Now, it would have the additional step of having Medicare pay the employer's share of what arguably is going to be a higher cost premium, and an extra burden on the Medicare trust fund. Why don't we simply allow the Medicare-eligible individuals to receive Medicare benefits rather than require the Medicare trust fund to pay these higher cost private coverage benefits under the alliance plan, and it also takes away the current bill, the beneficiary's current right to choose Medicare coverage over an employer-sponsored health plan. Why are we doing that?

Mr. VLADECK. Well, again, this was the issue we discussed at the conclusion of the last hearing, and there is a distinction. For Medicare workers, the total premium is at the community rate for the nonelderly population, so that when Medicare picks up the employer share of the premium for the worker who works part of the year, it is getting a very considerable bargain.

Chairman STARK. But wait a minute, and I don't know the answer to this but perhaps you know. When the person turns 65 and goes into Medicare, I don't know what percentage of those first year participants have a claim, but I will bet you it is like half, but for those half, let's say, maybe it is only 40 percent, for which we disburse nothing under Medicare, we are using that savings to pay for the 85-year-olds in Medicare.

The minute you keep them in a capitated plan and they turn 65, I am shelling out the capitated rate out of the Medicare trust fund for even those who cost us nothing, and that has got to be more expensive than what we are doing now.

Mr. VLADECK. You are paying a premium only if they leave work?

Chairman STARK. No, no, we are paying the premium in the first year that they are stuck in the plan.

Mr. VLADECK. Only if they begin the year—

Chairman STARK. But I am saying that has got to be higher and a drain on the Medicare trust fund because not 100 percent of those people will have any cost in the first year, and one assumes that we will be getting closer on a private side because we are paying 30 percent or more higher than we do under Medicare, we will be draining the trust fund.

Mr. VLADECK. But, again, we will be paying a very discounted rate for that person because we are paying at the 65 and under community rate.

Chairman STARK. Yes, but we are paying at 130 percent of Medicare payments because Medicare, as you have stated here, pays less than the private side, and we are paying for every individual, whereas—and you can get the numbers for me.

Mr. VLADECK. OK, we will.

Chairman STARK. How many first year Medicare beneficiaries file a claim? It certainly isn't 100 percent, but under this case 100 percent of everybody in Medicare under that proposal that stays in these plans would be paying a monthly charge of whatever the monthly premium is, and I submit that if you take those two you are adding an extra cost to Medicare. I don't know how significant it is.

Mr. VLADECK. We will get some numbers on that.

[The information follows:]

MEDICARE COSTS FOR UNEMPLOYED BENEFICIARIES WHO OPT TO REMAIN IN ALLIANCE
HEALTH PLANS

The Health Care Financing Administration does not keep statistics on how many Medicare beneficiaries file claims in their first year of enrollment. The closest approximation to this figure would be the number of claims filed by 65 year-old and 66 year-old Medicare beneficiaries: In 1991 this equalled 2.97 million.

But regardless of the number of claims, the Medicare program will not incur added costs for Medicare beneficiaries who choose to remain in their alliance health plan. Medicare beneficiaries can choose to remain in their alliance health plan only if that plan could qualify for a Medicare risk contract. In this case, Medicare would pay the alliance 95 percent of the AAPCC for each beneficiary; the same amount Medicare would pay for the beneficiary to be in that plan under the Medicare program. The beneficiary would be responsible for the difference between the alliance plan premium and the amount Medicare pays.

Chairman STARK. Mr. Thomas.

Mr. THOMAS. Thank you, Mr. Chairman.

To try to follow along on that same line just a little bit, I want to ask you some numbers questions just a little more, but in the later version, in the latest version, in the introduced version of the administration's plan, as I understand it, you are now requiring a State that if it wants to move any Medicare beneficiaries it has got to move all Medicare beneficiaries, is that correct?

Mr. VLADECK. In order to integrate the Medicare program completely into the State program, the State has to integrate the entire program. They can't exclude the disabled or the ESRD population.

Mr. THOMAS. But you just indicated to Mr. McDermott that never in our lifetimes will we see the integration.

Mr. VLADECK. In every State.

Mr. THOMAS. So the going is the goal, we are never ever going to get there.

Mr. VLADECK. Well, I think a number of States will seek to integrate the Medicare population at a very early stage in the process.

Mr. THOMAS. What rationale drove the administration to move from picking up certain classes of beneficiaries out of Medicare to requiring that they all get picked up? What happened between the earlier work sessions and the later work sessions to make it a selective absorption of Medicare versus an all or nothing? Doesn't that all or nothing shift, one, the timetable and, two, the view of the State vis-a-vis the Federal Government and what it is that the Feds are trying to tell them?

Mr. VLADECK. I don't think, as far as I understood it, it was ever the intent. If you look at the September 7 policy book or other earlier versions of the proposals I don't think it was ever the intent that a State would integrate Medicare into the State-administered program but exclude certain subclasses of the Medicare population.

How that appeared in the first draft bill is still not clear to me, and I think it was a mistake or an effort to overrefine this. But it makes no sense, from our perspective, to say to a State: "if you think you can do better in an integrated system, go ahead and do it, but you don't have to take the end stage renal disease patients or the adult disabled patients. You may leave us with the highest risk, most expensive and most difficult."

Mr. THOMAS. So you think it was a mistake. You think it was always the intent of the administration to want to make sure that the Medicare patients were capitated in terms of the concept of moving them into the States?

Mr. VLADECK. Well, it was always the intent that if the State was going to seek to integrate the Medicare program, it would be the whole program.

Mr. THOMAS. Do you think that slows down or speeds up the process that will never occur in our lifetime?

Mr. VLADECK. Frankly, I don't think it will make a material difference one way or the other.

Mr. THOMAS. Not in terms of any of the cost shifting that I see as a problem in terms of the Federal payments, both in terms of Medicare and Medicaid?

We are going to have cost shifting in this system. One of the reasons we are moving to reform under the Clinton plan, is to get rid of cost shifting. Let me just ask that question: Do you have any concern about a system as you envision it going into effect with significant cost shifting still occurring within an alliance? Do you think the cost shifting would be such that it would, in part, drive a decision as to how you deal with the Medicare patients in bringing them in?

Mr. VLADECK. I am not entirely sure what you mean by cost shifting, sir. People use that term in all sorts of ways.

Mr. THOMAS. What I mean by cost shifting is that some folks are paying more than they should pay because some providers are not being compensated for their actual costs. There is a cost shifting from one group to another. The classic example now is Medicare covering about 88 percent of the actual cost, the private sector about 128 to 130 percent of the cost. That gives you 100 percent for the whole universe.

One of the arguments for the requirement for everyone being covered under the President's plan was to get rid of the cost shifting.

My problem is that as I look at the alliances and folks who do not now have health care who are going to be guaranteed health care, as the President said, somebody is going to be paying for that. Within an alliance structure those people are going to be picked up. As you add the Medicaid and the Medicare people, if they are not being compensated at the full cost, back into the chairman's partial discussion, somebody is picking up that cost. That is a cost shift within the alliance structure. If you require all Medicare patients to be picked up now whereas before you were either silent or there was a mistake. At least then I could have seen an opportunity for an integration in a way that made sense to those State alliances and the structures that would have sped up the integration.

Once you say you have got to take everybody, I don't know what the message is that's sent. Either you want to make sure the Medi-

care folks are capitated or you are going to require some kind of movement in the system that I didn't envision before. So cost shifting to me is when somebody pays more than they otherwise would pay to cover costs that are less than actual costs. That would be the Medicare, the Medicaid, and the uninsured being picked up by the alliances.

Mr. VLADECK. Well, I don't know quite how to briefly comment on that, except to say that any insurance system is going to have some people costing more than other people. I don't believe at the moment that the Medicare program is paying too little to providers in general, and I don't think the issue of integration of the Medicare program into a State-operated system or an alliance system is going to revolve around this issue of cost shifting or not. It is going to hinge on the ability to integrate this population into a service delivery system. I think—

Mr. THOMAS. That plays directly into Mr. McDermott's hands when he starts talking about whether or not the Medicare costs are what other costs should be, but my problem in part goes back to the chairman's. That is: if your benefit package for everybody else is up here and your Medicare is lower, one of the real ways to reduce the cost shifting is to bring that package back down to a more basic package and allow the private sector on supplementals to move into some of those areas that are attractive but very expensive. There are a number of ways to bring those costs into balance.

I just have a difficult time with the new package in which you have got what I consider a relatively high benefits package, then a requirement that all Medicare be moved. I just think that you ought to look at the package itself.

For example, when we talked to the First Lady, my big concern was: Given the magnitude of these reductions which trigger the ability to put the system in, don't you want to guarantee the reductions first? The answer was: Well, we want to do them at the same time, the switch-of-hostages-on-the-bridge kind of thing.

One of the things in the Chafee-Thomas bill, which I think is absolutely critical as we move forward, is you certify the savings and then you plug them into the system in terms of bringing more people in. You earn by saving a larger coverage group. If we don't have some realistic component like that, we are going to go way away from the shore in terms of what we have promised and what we can deliver. That, to me, is one of the real fears under the President's current structure.

Thank you, Mr. Chairman.

Mr. VLADECK. If I may, sir, the opposite fear which, judging from the activity in the full House yesterday, strikes me as more immediate is that the Congress will take the savings and not do anything with the benefits.

Chairman STARK. Mr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

I would like to come back to the question of the intention of this bill. If I understand how it actually operates for senior citizens, they are going along and working and they are working on their 65th birthday. They do not go into Medicare. They have to stay in the alliance that is there under which they are presently insured; is that correct?

Mr. VLADECK. As long as they continue to work, yes, sir.

Mr. MCDERMOTT. Up to 10 hours.

Mr. VLADECK. Ten hours a week for 2 consecutive months.

Mr. MCDERMOTT. Now, tell me what you think the likelihood would be that anybody would keep on a 65-year-old on his or her 65th birthday if, as an employer, they could get rid of 80 percent of the premium.

Mr. VLADECK. Again, there is a community-rated premium, so if they get rid of the 65-year-old and hire a 25-year-old, the employer's benefit cost is the same. It makes no difference to the employer the age or risk of the employee under that agreement.

Chairman STARK. Not in a part-time world. Nordstrom, McDonalds, who are all running part-time folks, would, if this person is working part-time, let them go and increase a few hours, so there is no increase in the fixed cost of the current part-time employees.

Mr. VLADECK. But the design of the employer obligation for premiums under the plan should largely render the employer indifferent. If you are going to get X hours of labor under the plan as an employer, you are going to pay the same amount whether you have four people working 10 hours a week or one person working 40 hours a week. You are going to have the same premium cost whether it is a 25-year-old or a 75-year-old. If they are employed, the employer's cost is the same regardless of age or the number of workers that comprise one full work week.

Chairman STARK. Based on a 30-hour work week, though.

Mr. VLADECK. The difference is whether you have somebody at 29 hours, in which case you pay 94 percent of the 80 percent, or somebody at 30 hours, in which case you pay a hundred percent. There is always a notch, but it doesn't matter about the premium obligation.

Mr. THOMAS. Come up with another term. Don't use "notch".

Mr. MCDERMOTT. I think my question turned out to be red meat here.

I have another question. As I listen to this discussion about costs and savings, it strikes me—and I want to ask you to make sure I understand the belief of the administration on this issue—if you do not have universal coverage, you cannot get cost controls; is that correct or not?

Mr. VLADECK. That is our absolute belief; yes, sir.

Mr. MCDERMOTT. So any plan that has anything less than universal coverage, everybody covered, everybody in the boat, is not going to achieve cost savings?

Mr. VLADECK. Not nearly of the size we hope to get; no.

Mr. MCDERMOTT. Now you are hedging.

Mr. VLADECK. I think you can do some things about reducing the rate of growth short of universal coverage, but in terms of very substantial savings, I don't believe you can get it.

Mr. MCDERMOTT. You can always reduce the Government's cost, but the overall cost of health care expenditures, unless you have everybody in, it is pretty hard to get any cost savings; isn't it?

As long as you have any significant—if you have 10 percent of the people uncovered or 5 percent.

Mr. VLADECK. It is almost impossible to do it. The only way to do it is with a very strict regulatory program.

Mr. McDERMOTT. So anybody who wants a plan, who wants cost savings but doesn't guarantee universal coverage is really relegated to the role of asking for a regulated system, tightly regulated system?

Mr. VLADECK. I think so yes, sir.

Mr. McDERMOTT. Thank you, Mr. Chairman.

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON. Thank you, Mr. Chairman.

In your testimony, Mr. Vladeck, you say that there will be expanded opportunities to participate in managed care.

Could you enlarge on that?

Mr. VLADECK. We have undertaken a number of steps to try to strengthen the Medicare managed care program, and the bill specifically proposes a more orderly open enrollment process annually in each area with our control either directly or through a third party of the marketing material, et cetera, to try to give beneficiaries a much better and more informed choice.

Mrs. JOHNSON. Are you envisioning expanding Medicare select or are you just envisioning giving Medicare recipients a choice of existing private programs?

Mr. VLADECK. We are envisioning several things. One is an expansion of the number of HMOs participating in the risk contracting program.

A second is the development of a Medicare preferred provider or point of service program on which we begin to hold demonstration projects in the near future.

Third is further evolution of the medigap market, some of which will embody some of the principles now contained in the Medicare select program.

Mrs. JOHNSON. But you don't specifically expect to continue the Medicare select program?

Mr. VLADECK. Not by itself. Only within the context of a much broader set of changes.

Mrs. JOHNSON. To get back to the issue of your projected savings in Medicare, could you be specific about how you are going to achieve them? To this point in time, representatives of the administration have spoken primarily about a systemic reduction in costs that is going to accompany the adoption of their program and that that systemic reduction will enable you to realize those savings without impacting beneficiaries.

Could you be more specific?

Mr. VLADECK. We do have 28 specific items listed in my testimony. I could enumerate them one at a time if you wish.

Mrs. JOHNSON. Sorry, I missed that part of your testimony. I will look at it more carefully.

If you could point to the two or three strategies that are most different from what Medicare has done in the past, that you expect to achieve significant savings, that would be helpful.

Mr. VLADECK. I think most of the savings reflect continuations of things this Congress has done in the past; about a quarter of them essentially involve extending existing provisions that have been adopted in previous reconciliation bills or elsewhere that expire at some point over the next number of years and that we seek to extend through the year 2000.

Roughly another quarter of the savings are from expenditures currently in the system that are attributable, in effect, to subsidizing uncompensated care through the disproportionate share hospital payments, medical adjustments and things of that sort which will be significantly reduced in a world of universal coverage.

The other proposals, if I can lump them together and characterize a strategy as opposed to a set of tactics associated with them, primarily have to do with introducing the principles of competition more directly into the Medicare program; specifically, promoting competitive bidding for laboratory services and for certain other part B services and seeking to reform some of the ways in which we pay for certain high volume services such as coronary bypass or cataract surgery by expansion of our very limited, preferred provider demonstrations.

So those are the three primary thrusts which I guess account for perhaps two-thirds of the total savings we are proposing. The rest consist of a variety of other things that have been floating around in one discussion or another in the past, all of which we think make sense whether they have to do with the incorporation of the remaining State and local employees in paying the HI tax or whether they have to do with further refinements of payments for certain categories of facilities or providers.

Mrs. JOHNSON. Thank you, Mr. Vladeck.

Chairman STARK. Bruce, you have, I presume, seen, unless it was passed around to us as a complete phony document, some kind of a document prepared in Health and Human Services that anticipated the National Health Board would require about 8,000 full-time employees, about 6,000 of which would exist in other agencies and about 2,000 of which would be new employees. I don't know whether that was just an estimate, or what it was prepared for, but you have seen the document?

Mr. VLADECK. I have seen a document, but we have never seen a document from the Department of Health and Human Services that talked about several thousand employees for the National Health Board.

Chairman STARK. We will get a copy in a minute. It was interesting that there were a thousand in the fifth year for Medicare bidding—I can't think exactly what it was, but I presume that in that—it talked about several billion dollars a year to run this thing—it was 2,000 employees in the fifth year, full-time employees of the Health Board.

Those would be new and 6,000 which they would reach out and use other—I will get the copy here and see if you have seen it. But in the proposal there is a competitive bidding procedure for MRIs, CAT scans, DMEs, et cetera there is that proposal; is there not?

Mr. VLADECK. There is a proposal; yes, sir.

Chairman STARK. If somebody gets the bid in the neighborhood, and suppose they are smart enough to low ball it, what happens to the other providers? They just go out of business and go away and then what is to prevent the survivor from jacking up the price in subsequent years?

Mr. VLADECK. I think that is a real risk in competitive bidding. That is why a smart buyer in writing the statutory language for

a bidding process and in selecting vendors doesn't permit that to happen.

Chairman STARK. HCFA did a study. You asked outside consultants to look at the competitive bidding process in the past; did you?

Mr. VLADECK. Possibly.

Chairman STARK. What were the results of that study?

Mr. VLADECK. That, I haven't seen.

Chairman STARK. Could we get a copy of that study?

Mr. VLADECK. After I see it, you will get it next.

Chairman STARK. I suspect there is no way to prevent that, and I have no reason to shill for the radiologists and more MRIs, but the fact is that you set up a system in a community where somebody gets the exclusive contract effectively because there is no copay for Medicare beneficiaries, I understand that is the reason they go there, they soon pick up the lion's share of the business and then you don't have anybody else in the second or third go-around to bid against them and you have put yourself in the position of having a single source supplier and you look to the Pentagon to see what that does. But I would like to see——

Mr. VLADECK. If there is such a document, I will be happy to share it with the committee.

Chairman STARK. Under the President's plan, 15 percent of physician payments to physicians in hospitals with high levels of physician services would be withheld at the beginning of the year. At the end of the year, some of that money would be returned.

In fact, in the changes, I guess, the withheld amount could all be returned to the physicians in those hospitals. Can you outline for us how that policy would be administered and which hospitals would be affected, urban hospitals, teaching, nonteaching?

Mr. VLADECK. Well, this is a proposal that grows out of our frustration that even under the Medicare fee schedule and even with some of the other changes that have occurred, we still get hot spots, as it were, of areas or communities with extraordinarily high utilization that doesn't seem to be explained by any particular characteristics of the population of beneficiaries being treated.

This proposal is an effort to begin to define some limits around how much you will pay for hospital-based physician services within a community. In principle, it adjusts for case mix intensity in the individual hospital and then looks at total physician billings associated with that particular case mix and tries to draw some boundaries of reasonable variation around that.

The withhold is just the mechanism by which payment in excess of those boundaries is avoided and it provides an incentive to the medical staff of the institution to be more careful in their use of services. This is a proposal that is still at relatively early stages of figuring out the detail.

If you look at the chart, you will see that we don't propose to implement it until fiscal year 1998, in part because it is a complicated thing and we are trying to figure out ways to address the same objectives more simply and with less complication. We will be happy to work with you and try to figure out how to get more straightforward and more focused.

Chairman STARK. Thank you very much. Mr. Thomas.

Mr. THOMAS. Thank you, Mr. Chairman.

One of my real fears is that as we move forward in this and the role of government as outlined by the chairman in terms of producing a bidding structure, which by itself guarantees that we do not have a successful second or third round, should require all of us to go back to the 1950s and read President Eisenhower's admonition about the military industrial complex, and the potential for that in the year 2000 with the health care system in the United States and the role of government is one which concerns me a lot.

It is one I wrestle with as we move forward on these changes. The thing we have to remember going back to your discussion with Dr. McDermott in terms of universal coverage and the requirement for significant regulation, if you don't have universal coverage, under the Clinton plan when is universal coverage contemplated?

Mr. VLADECK. January 1, 1998.

Mr. THOMAS. So 1998 is when you hope to achieve universal coverage, everybody gets that health safety card. Assuming that this unprecedented reversal of the cost spiral for Medicare and Medicaid occurs, and the targeted savings as outlined here with the hope and promise actually occur. The 1998 date I am sure has been scrubbed as have the other numbers. If everything else occurs, we will reach the 1998 date, what happens if we don't?

Mr. VLADECK. I think the estimated savings are indeed predicated on coming to universal coverage in 1998 and achieving most of the private sector savings thereafter. If it gets delayed, the savings get delayed.

Mr. THOMAS. The savings get delayed, not the coverage.

Mr. VLADECK. The savings come after the coverage, simultaneous with and after the coverage.

Mr. THOMAS. But if we don't get the savings, do we get the coverage anyway?

Mr. VLADECK. You get the coverage and then you get the savings is the logic of the estimates. You can get the coverage without the savings; you can't get the savings without the coverage.

Mr. THOMAS. I remind you of the statement you just made about the battle on the Floor last night. I have no doubt about this Congress' and Government's ability to extend promises and to provide benefits. I am extremely concerned about the will to pay for them, which has been part of our problem.

That is why, once again, I am starting to honk the proposal that Senator Chafee and I have just introduced. We talk about universal coverage in the year 2003 or 2005, but do it in a way that extends coverage after we have achieved the savings. Frankly, if you were to put it to a query as to whether you want a hope and a promise based upon Congress' ability to perform in terms of achieved savings, versus a 1998 date for complete coverage or 2003 or 2005 date based upon the actual savings having been made. I think the differences are not significant. The way in which we do it, I think, is far more significant than the time at which we do it.

The other thing is that the longer we go in this, the more I am pleased with the numbers that are coming in regarding the reduction without doing anything. It is akin to the Vice President's statement when this administration was first elected. I recall, sitting there watching the Today Show in which they introduced that stimulus package, and the Vice President seemed to be amazed at

the way in which the economy was picking up just by virtue of the introduction of the stimulus package.

It appears that just the introduction of the Clinton plan has brought about significant savings in the private sector. I think what is happening is people are waking up and looking at the alternative and therefore deciding to do something about it. I also think, more importantly, your average consumer of health care is getting more educated and employers are getting smarter about the way in which they can go about it.

Do you believe that if the cost increases in the health service area were in the 4 to 6 percent growth rate—which appears to be where we are going to hit somewhere in the 1993–94 period—in 1988, 1989, 1990, 1991, that we would have felt compelled to go down the path we are going down now?

Mr. VLADECK. I think the acceleration of the rate of health care costs in the latter part of the 1980s and the absence of an obvious prospect for a deceleration by itself has a lot to do with the timing and the mechanics of this proposal. It has made getting universal coverage extraordinarily more difficult.

Mr. THOMAS. Do you believe there is a decelerating of the cost increases as compared to the late 1980 period.

Mr. VLADECK. We are seeing that this year. Our experience from the late 1970s suggests it may be very transitory.

Mr. THOMAS. My suggestion is that given the fundamental kind of changes, the involvement of individuals in various cost savings programs, the movement toward managed care on a broad basis and a better understanding of the mechanics of managed care, government could do a few things like malpractice reform and anti-trust reform. The administration has done some in that area, but we need to do far more, which would help alleviate the problem of the bidding business if you can get professionals together on a co-operative basis.

If you have insurance reform, you would see a permanent acceleration of the reduction by virtue of umbrella changes and administrative simplification in other areas. I guess I should leave this segment with the question that if, in fact, the current practices were the practices when the policy was put together, do you think the same policy would have come out? Would the same program that the President is offering have come if the numbers had been what they appear to be now, a 4 to 6 percent growth rate?

Mr. VLADECK. No nation in the world has ever sustained that low a growth rate in the absence of universal coverage or some aggregate national limit on expenditures.

Mr. THOMAS. I understand that, but do you believe the administration would have produced the same program had the numbers been in the 4 to 6 percent rate?

Mr. VLADECK. Over the last 5 years, no. We could have gotten to universal coverage much more quickly with fewer savings in the public program.

Mr. THOMAS. So the Clinton program is based upon numbers that are not now being registered on the cost increases. Maybe they are transitory, but they are based upon far higher cost increases.

Mr. VLADECK. It is based on the actual empirical experience of the last 15 years; yes, sir.

Chairman STARK. Mr. McDermott.

Mr. McDERMOTT. Let me come back to another question. Unfortunately, this thing is like a spider web, you can't touch one thing without touching a bunch of things. Funding for medical schools is a sort of a gerry-rigged operation in almost every State, including the big city hospital that provides patients, and you have the students spread out and the residents spread out through all the hospitals and you have all these various mechanisms and your plan touches a whole bunch of them at once.

You made some assumption about big companies going into corporate alliances. You will then hit them for 1 percent that will be used for medical centers and there is some assumption—I can't see why a company wouldn't want to just go into the regular alliance and save the 1 percent. That is not this discussion.

The question I have is, as I read through your Medicare part A reductions here, you reduce the indirect medical education adjustment factor from 7.7 percent to 3 percent in 1996. Studies over the years have shown that the current level of IME adjustment is not justified and that it overcompensates teaching hospitals for their indirect costs so you save \$17.8 billion.

Are those studies available that some of us could see?

Mr. VLADECK. Absolutely; yes.

Mr. McDERMOTT. I would hope you would send them up here. Why do you pick 3 percent over 7.7? You just needed a certain amount of money so you reduced that particular place so that you would have the desired result or is there some basis on which that is arrived at?

Mr. VLADECK. Those numbers are based on one set of empirical estimates of the actual indirect contribution of medical education activities to the costs of operating a hospital. There are other estimates around which range anywhere from the 3 percent to the order of 5 percent. They are all significantly below 7.7 percent.

But we have also proposed in this plan a mechanism to fund the indirect costs through a national pool and we think 3 percent is consistent both with some of the reasonable empirical estimates and also with getting the Medicare share of the total dollars in that pool to be an appropriate amount.

We think Medicare has probably been doing more than its share subsidizing medical education in the past than it should have. For the pools that we propose at a 3 percent IME rate, Medicare's contribution works out between 25 and 30 percent of the total pool, which we think is about the right number.

Mr. McDERMOTT. So you will take this 3 percent money and put it into a pool and then there will be some kind of scrambling around between the University of Washington and whatever in New York City, Cornell Medical School, will each be arguing that they deserve more of that pool than the next hospital; is that what we are setting up here?

Mr. VLADECK. We are moving in the direction of someone making some decisions, starting from the existing historical base, about where changes in the flow of that money ought to take place.

Mr. McDERMOTT. Who would be the person and what would be the organization that would have this pool of 3 percent money and decide who got what?

Mr. VLADECK. As I understand the bill, the money will be allocated by the Secretary of HHS in response to recommendations by a substantially reconstituted and strengthened Council on Graduate Medical Education, which is comprised largely of the representatives of the academic medical community.

Mr. McDERMOTT. Let me go to the disproportionate share, because having been a State legislator, I know a little bit about this element and I know how it is woven into the fabric of the way States finance their big city hospitals. Its says hospitals that have a disproportionate share of low income patients will receive an additional payment for Medicare.

How is this new system to going to work? I see that your 6-year savings is 14.6, so you are saying by 1998 you will have universal coverage so presumably you won't need disproportionate share at all at that point; is that correct?

Mr. VLADECK. We think you still need Medicare disproportionate share payments because in low income communities it is more expensive to care for Medicare beneficiaries than it is to care for them in other communities.

Mr. McDERMOTT. Why is that?

Mr. VLADECK. Two reasons. One is that there is some cost of doing business associated with particular inner city locations in terms of premiums. You end up paying for personnel for security. All things being equal, it is more expensive to provide hospital treatment for a hip fracture for a Medicare beneficiary in inner city Brooklyn or inner city Seattle than it is in the suburbs of either of those cities.

Second, even as our DRG measurements get better, all other things being equal, we suspect that a low income Medicare patient in DRG X is somewhat more expensive to care for than a middle or upper-income Medicare patient in DRG X because of the greater likelihood of unmeasured complicating conditions, limited social and family supports, et cetera.

So it is more expensive to take care of low income people, all things being equal, in the Medicare program than non-low-income people, and that is what the residual part of the disproportionate share payment is intended for in our proposal. The major technical change associated with the proposal is how you measure disproportionate share since the current measurement relies on the number of Medicare beneficiaries who are also receiving Medicaid.

If you restructure the Medicaid program, that becomes a less reliable measure or a very different measure from what we now have and, therefore, we propose to tie the measurement of disproportionate share under reform to simply the number of Medicare patients who are also SSI beneficiaries, which is already part of the current formula and something we know we will be able to count even after reform.

Mr. McDERMOTT. How much money do you spend in disproportionate share now or would you anticipate spending over the next 6 years—what kind of savings are we looking at with 14.—is that 10 percent savings or 50 percent reduction or 75 percent reduction?

Mr. VLADECK. At the end of the phasedown, there is about a 70 percent reduction in the total amount of disproportionate share

payments. So, over the 5-year period, there is a reduction of roughly half of what we would be spending.

Mr. McDERMOTT. Some of it beginning in 1996?

Mr. VLADECK. As the individual States implement it; yes, sir.

Mr. McDERMOTT. So there will be no reduction in a State until they implement a health plan, put in the alliances and they are up and running?

Mr. VLADECK. Until there is universal coverage in the State, the Medicare disproportionate share policy will remain unchanged. Once there is coverage, it will be phased down to approximately 30 percent of its present level.

Mr. McDERMOTT. So the incentive of the State is not to implement—at least this particular incentive is not to implement immediately?

Mr. VLADECK. If they were looking only at disproportionate share payments, yes, it would be an advantage to stay out longer. We think there are countervailing financial incentives for the States to come in sooner, particularly relating to getting a cap on their Medicaid outlays.

Mr. McDERMOTT. A cap.

Mr. VLADECK. Once a Medicaid population is in the alliance, the growth of the State payments for those folks is capped.

Mr. McDERMOTT. Thank you, Mr. Chairman.

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON. Thank you, Mr. Chairman.

In looking through your part A, the impact of changes in hospital payments, each item runs somewhere between \$10 and \$18 billion in cutting hospital reimbursements, but when you get into the part B section, there are also things with heavy hospital impacts. Your effort to eliminate the hospital outpatient overpayment, you note that because of the flaw in the services using a blended payment, because of the flaw in the statutory payment formula, which assumes a lower coinsurance payment than is actually made, this item will save another almost \$13 billion.

At some point—I don't think this hearing can provide the opportunity, but I would like to understand better what that flaw is and how all of these payments are going to interact, because it looks to me like the impact the first year is going to be very heavy on the hospitals.

Let me go to Medicare part B and your first three bullets, because the interaction of these three items appears to repeatedly disregard experience with volume. In bullet 2, establish cumulative MVPS rates of increase specifically says we are going to discount the prior year's actual rate of growth.

We put that in there for a purpose, because we were going to estimate what the rate of growth was going to be. When we saw what it was exactly, we were going to take that into account. Rate of growth is going to be discounted in that bullet.

In the next bullet, you refer to an unreasonably high volume and intensity levels; by whose measure? If you are going to discount volume and the conversion factor and you are going to disregard experience of volume in the MVPS rates of increase and then in the first item where you talk about volume intensity factor, you are going to arbitrarily limit that to a 1.5 increase of GDP.

You are relating growth in physician services to growth in the economy. The growth in physician services has to do with people and intensity, not with growth in the economy. So I worry about the repeated effort to disregard volume and intensity and its impact on Medicare recipients.

Mr. VLADECK. I don't believe we are seeking to disregard volume and intensity. I think we are seeking to correct some characteristics of the existing Medicare fee schedule that are producing increases in fees that seem to us to be disproportionate and inappropriate. There was a presumption made when the fee schedule was initiated that the very existence of a fee schedule would cause a behavioral response on the part of physicians that would produce a very significant increase in the volume of services for which they were building the program and there were a series of formulas built in to reflect that.

In fact the actual experience under the Medicare physician fee schedule in the 18 months for which we have data is that the volume of services physicians are billing is much less than had been projected by these various complicated formulas. As a result, the formula produced an update in surgeons' fees, for example, for calendar 1994 of somewhere in excess of 12 percent. The Congress brought that down 50 percent in the course of reconciliation, but the very fact that that sort of number popped out of these formulas suggested that there is something that ought to be looked at again in terms of these formulas.

Mrs. JOHNSON. Was that popping out because of the target that had been set in preceding years so that as volume went down, then payment for action went up?

Mr. VLADECK. But it was not so much because volume per se went down, although it did slightly, it is because volume was less than projected on the basis of a formula which we believe significantly overprojects volume. We are trying to get the formula tied to a more rational base.

Mrs. JOHNSON. I look forward to talking with you or your staff at some later date in greater detail about this. When we have adjusted this formula in past times we have come out with impacts in my part of the country that have been irrational and that have made access to services far more difficult for Medicare recipients. So to see you tying things to GDP and an intention to disregard growth and volume is disturbing to me.

Thank you.

Chairman STARK. Bruce, is there a group called the Steering Committee of the Health and Human Services Health Reform Implementation Tax Force, something like that, existing over there?

Mr. VLADECK. Apparently there is, yes, sir.

Chairman STARK. I have here a rather detailed, what appears to be a work product. It is conceivable that I am the victim of a gross hoax.

Mr. VLADECK. I can't conceive of that.

Chairman STARK. I can. Perpetrated maybe actually in the guise of Ira Magaziner. Nonetheless, I was told that maybe because it was dated December 3, this was changed in time for the planned bill to be introduced. There is a supplemental piece here that has a date 9/16/93 on it where—that is somewhere around the introduc-

tion date. To get to the bottom line one says Donna Shalala and it deals with full-time employees of 4,357 in the first year, going to 8,822 in the fifth year; and it talks about \$3.5 billion a year in cost, 1.8—in round figures, \$1.9 billion in the first year.

And one of the areas that I was concerned about initially goes back I suspect to this bidding process. There was 900, a thousand employees in the fifth year who were needed for some kind of Medicare managed care program, and expanded Medicare managed care options gets us to a thousand employees out of that couple of thousand.

Now, for a little bitty itty board, minor board as I have heard, with only prospectively 200 employees, to get to this package of—the administrative costs of \$1.7 billion, data systems, I have a big ticket items, \$4.8 billion for hardware and software, \$3 billion for the Medicare drug benefit, quality management, \$1.2 billion—all of this sounds like things that you already so ably do, and I have a little trouble figuring out where you are going to put—2,300, 2,700 employees—you don't have that many running Medicare now, do you?

Mr. VLADECK. We have a total of 4,000 employees in HCFA.

Chairman STARK. You have a couple hundred working on Medicaid, a couple hundred working on fraud and abuse. Where are you going to put all these employees? They have the number of square footage here that you are going to need. The real estate industry in the District of Columbia is going to dance in the streets tonight.

My point is do you have a more current estimate? Can you talk to the work group, Eileen Bradley, Anna Durand, Barbara Robbins, are any of those people here today?

Mr. VLADECK. No.

Chairman STARK. Are they still working for you? Could we get a little more up-to-date on what this may cost the public and what is involved?

Mr. VLADECK. Let me say a few things about that document, Mr. Chairman.

First, there was an internal working document that had certain wish-list characteristics to it since everybody in the department was asked how many people they would need to do various things. They responded, as you would expect, and it was prepared for purposes of submission to OMB for determination of the administrative costs that would be included in the proposal.

I don't know offhand the exact numbers of new Federal administrative costs in the proposal, but my perception is it is somewhere between \$1 billion and \$2 billion per year for each of the years in the window.

Now, as far as what HCFA expects to do, that administrative cost includes, for example, administration of a new drug benefit with the gross benefit payments before rebates at full implementation in excess of \$20 billion a year. We estimate paying on the order of a billion claims a year, so that at 75 cents to a dollar a claim, that is still a substantial administrative—

Chairman STARK. You don't intend to contract that out to intermediaries?

Mr. VLADECK. We do, so it doesn't require a lot of full-time employees but there is significant administrative expense. We now

maintain a data system on about 50 million people in terms of their enrollment and utilization. If there is to be a national data system, that is a fivefold increase.

Chairman STARK. What I am getting at is that what we had heard, this presumes that this is going to come under the aegis of some new board. Now, I can see my friends from ProPAC in the audience licking their chops. They are all going to quit and get on this new board with 8,000 employees.

Couldn't we do this more efficiently within Health and Human Services? Is HCFA admirably staffed and directed to handle this?

Mr. VLADECK. "Aegis" is an appropriate word, Mr. Chairman, because that is the role of the board to a considerable extent. We are talking about a board of a couple of hundred employees contracting with or delegating primarily for these functions to HHS for these activities.

Chairman STARK. That doesn't wash with this report. I just want some assurance—200 people with—how many employees do ProPAC and PhysPRC have each?

Mr. ALTMAN. Twenty-five.

Chairman STARK. That sounds reasonable. We are going to keep this thing in bounds, then you guys do the rest. Are you capable of handling all this in your department now with added resources?

Mr. VLADECK. We believe we are, yes.

Chairman STARK. Without a whole new set of management structure; management is tough and lean and aggressive in HCFA, is it not?

Mr. VLADECK. Not all of us are lean, but we have all the other characteristics.

Chairman STARK. What I guess I am saying I would like some sense of esprit de corps of a willingness to get this job done with the existing structure.

Mr. VLADECK. If Congress decides to do it, we are ready.

Chairman STARK. You will find room in your heart for Anna Durand and her three associates who spoke out. This was tossed around the Hill by some enterprising reporter and not by, as far as we know, any of the folks on this group, but it does show a wildly different approach to this idea of a 200-person board, and I hope that we can—if there are these disparities—it would be far easier for us to work with you if we had some indication that there is some difference in numbers rather than to have these things tossed over our transom in the middle of the evening.

Mr. VLADECK. I believe that by the time of the submission of the President's budget for next year, we will have not only the 1995 budget, but estimates of the very specific incremental budgetary implications of reform, and we would certainly be happy to talk to you about that.

Chairman STARK. Would you have a more updated version of that report that would give us some idea of how we get closer to the 25?

Mr. VLADECK. The one thing I can tell you is that we have a commitment that total employment in the Department of Health and Human Services will be no greater when health care reform is fully implemented than it is now.

Chairman STARK. That doesn't help me if you contract it out.

Mr. VLADECK. Further, under the President's Executive Order we are contemplating, all other things being equal, a reduction in the total complement at HHS. I think it is best to put it in dollar terms, which is, I think, at a peak the year of implementation because of startup costs. The current estimates and the figures associated with the plan are something under \$2 billion a year in incremental administrative costs with the steady state being somewhat closer to a billion dollars a year. We will be able to give you more detail in the near future.

Chairman STARK. Mr. Thomas.

Mr. THOMAS. Mr. Chairman, I have accepted a kind offer from Dr. Bob Blandon at the Harvard School of Public Health to pull together the various polling data to periodically keep us informed of what folk in various slices of the polling universe think. It is ironic that after the exchange with the chairman that no one disbelieves the figure that 70 percent of the American people believe that the administration is not telling everything about the plan, or 54 percent believe that it is too complicated to work.

You folks need to continue to work to knock those numbers down, but I have to tell you that sitting here enviously looking at the leaked materials that the chairman has as the gentlewoman from Connecticut leans over to me and asks; do we have that? The answer is I don't know. People keep giving us stuff.

There is an underground market for month-old memos inside your structure, and you folk need to, if you will, own up on everything that this plan has. If not, that 70 percent of the American public, believing that you are not telling everything there is to know about the program, is going to begin to eat away at a reservoir of desire for change.

I am about ready to go to the next panel but you know that you are not allowed to have the last word around here. You mentioned at the end of my 5-minute period indicating that you based the President's plan over data over the last 15 years, so I want to revisit that statement before I move on to the next panel.

Are you willing to concede at all that the President's plan may have had a similar effect, as the Vice President indicated, on the stimulation of the economy from the stimulus plan of the President? In other words, once the health care industry understood that the game was up, that is, this structure appeared to have a resonance despite doubt that things were going to be different, did folks change? I won't even be that cynical because if you take a snapshot of the last 3 years, look where the States were in 1989 and 1990 and then look what they have done in 1991, 1992 and 1993.

California has a malpractice law in place. Thirty-one million people, many of them lawyers and doctors, have decided that they are going to give up the game to a certain extent. To me that is unbelievable.

I talked to the American Medical Association, the doctors are today talking far differently than they were 3 and 5 years ago. The insurance industry used to be fairly arrogant. They walked up here on the Hill with a swagger. Now they are coming into the office asking; is there a role for us?

You folks have changed the perspective of a lot of folks. The delivery system—I talked about California becoming a managed care State. We have a volunteer HIPC. We are up and running with a lot of novel stuff.

So when you talked about the end statement based on 15 years, that doesn't mean anything in terms of the mental set of the changing world today. You are probably not the appropriate person to address this to, and I want to continue it with others, but don't you believe that over the last 3 years and with the trends being set in place by the private sector, that some of the conceptual framework of what we needed to do, as evidenced in the President's plan can possibly be adjusted. That is why I give full credit to the President for saying here is our work product now, take a look at where we are going. Don't you think that in a reaction to the last 3 years and what appears to be a continuing trend, it should give some glimmer of hope that the statistics over the last 15 years are historical and are not a trend for the future, and the current figures are not an anomaly and may tend to become more permanent than would otherwise be the case?

Mr. VLADECK. No, sir. I believe that unless we move reasonably soon to universal coverage in some system that has a backup, formal, legal constraint on it, after some period of time the cost curve will begin to climb very much more radically again.

Mr. THOMAS. So the President's offer that "hey, folks, if you think we can make major adjustments to this as we go along, I am open to it" was really not realistic. In other words that you need the complete structure that the President has offered?

Mr. VLADECK. Sir, in the context of a 1,300-page bill, I think universal coverage and budget discipline hardly comprises the complete structure. The President has said those are the bottom line and everything else within that is open for discussion.

Mr. THOMAS. All right.

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON. I would like to just ask you to submit to me as a followup of this hearing a different format of the information you have provided to us. I would like you to outline for us year-by-year, instead of over 5 years, the cost savings in each category. In other words, how much are hospital reimbursements going to be cut by each of the individual bullets you have here each year, and what is the logic for that cut so that we can get a better grasp. I am sure you are familiar with Martin Feldstein's testimony before this committee.

While he was using your earlier estimates, one of the very important things we are going to have to decide, probably the most important judgment we will have to make, is whether or not the cuts you are proposing each year are going to reduce access to services by under-reimbursing providers or whether they are not, and whether you are going to be able to achieve the services you are saying you are going to be able to achieve or you aren't.

I would remind you that in a much simpler world, CBO has found it very difficult to estimate the cost of Medicare or Medicaid, and so just in 2 years they made "technical changes" to the Medicare baseline that brought the cost from an estimated \$790 billion to \$841 billion dollars, a \$50 billion difference in 2 years, that

doesn't even show up in our budget in a way that we are required to pay for them. This is why the deficit is going where it is going.

There are a lot of ways in which costs go up and Congress never has to pay attention and we never have to pay. If Medicare went up \$50 billion under the old system in 2 years without our being able to foresee it, then we have to look at your year-by-year estimates and the logic for them and evaluate is this going to help us or is this going to hurt us?

In 5 years are we going to be looking back and the technical corrections are going to be changing the baseline \$200 billion rather than \$50 billion.

So I thank you for the detail in your testimony. It is far more detailed than at least I have received to this point, though clearly not more detailed than the chairman has received to this point. I would ask you to present it in a way that is somewhat less technical and more easily accessible so that we can begin to work on the judgments that clearly we are going to have to make hopefully together.

Mr. VLADECK. There is an attachment to the testimony headed "Medicare under Health Care Reform" which has year-by-year tables. Did you not receive that?

Mrs. JOHNSON. I don't know. We receive this testimony the moment the hearing starts.

Mr. VLADECK. We will make sure you get it.

Mrs. JOHNSON. I will look over that. I see that it is year-by-year and I don't see that that satisfies my concern. I think that you can expect that it doesn't entirely. We need to get a clearer picture behind some of the more technical phrases as to the impact on a sample hospital, the impact on a sample physician in different parts of the country, because behind your cuts is an extraordinary reduction, so extraordinary that no other nation in the whole world has achieved it.

So what you are asking us to buy into is without precedent in America or any other country regardless of how much control and power they have over health care spending. I appreciate the new detailed information, but you need to come forward with perhaps examples, but something that we can send out to our hospitals that they might hope to understand and that we can look at what the real world impact is going to be.

In my district, I have only one hospital that gets a disproportionate share payment. All the rest are smaller hospitals that have a hard time in our system anyway, because they don't show up on Washington's radar screen. But they are very important to the quality of care, particularly to seniors. Thank you.

Chairman STARK. Thank you.

Bruce, is there a date fairly certain that we could expect an interim prospective on the payment system for skilled nursing and home health?

Mr. VLADECK. I would be reluctant to give you a date. There is something in the works. We have heard both from you and your counterpart in the Senate loud and clear, and we are pushing that as fast as we can, but I can't yet give you a date.

Chairman STARK. I certainly won't—not the kind of deals they were passing on the vote for NAFTA, but there was an inclination

in the previous administration to which many members of this subcommittee subscribed that for an agreement, I guess, to do away with the return on equity which a lot of us didn't like, that there would be a relatively—within a year, say, of a proposal so we could get to a payment system for skilled nursing and home health, and I would hope, and this doesn't have a whole lot to do with health reform save the Chair's concern that if we make deals with providers, we have a lot more credibility if we can make some progress toward that. And I would like very much to encourage you, even if we had a first study or report, to make some movement in that direction.

Mr. VLADECK. I don't know, again, exactly the date at which we can deliver a complete report on a prospective payment system for skilled nursing—and for home health it is even more complicated.

Chairman STARK. I understand, but that is what ran us \$10 million off the scale.

Mr. VLADECK. Let me promise you the following. We will have interim proposals within the next 6 months or so as we move in the direction of a more systemic approach.

Chairman STARK. This isn't your bailiwick, but let me ask you if you could get us some numbers.

The idea of using SSI, when I asked you the first time I was unaware that the rural hospitals have been promised an exemption. They are held harmless. You are taking the inner-city hospitals on disproportionate share, the theory being there will no longer be uninsured people, that you still need assistance to those hospitals.

SSI, I think, is a bad proxy. It is so different that I would like some more thought given to what we are going to do with these inner-city hospitals, because at least on the House side I think you are going to find that that will be, if not a humanitarian concern, a rather critical political concern, as much of a concern as arguably the rural hospitals are on the Senate side.

It is not that I question the intention. It is just that I have a hunch that somebody who knew nothing about public assistance just picked SSI as a number to use and I hope you could look at that and give us some kind of an indication about what kind of a system might be used.

Then I would wind up by saying that something that I find missing—actually I would say in every plan I have looked at, but spectacularly so in the President's plan is the issue of resource allocation and capital.

Chairman STARK. There is nothing. I mean, one could make the assumption, as Dr. McDermott was just saying, that if the system works, the big hospitals will be so efficient they will have all this capital, they will buy all the capital—I am not sure that system would work. I know you would agree with me that New York is woefully short of capital relative to, say, California, which has an embarrassment of probably too much in the way of capital resources. Is that a fair assessment of the present state of our system?

Mr. VLADECK. I am not sure I would say New York has too little. I am not sure it is in the right places.

Chairman STARK. All right. So when you talk about trauma care, very expensive new high-tech equipment, there is no procedure

here to allocate that, and while I might say we could go back to CONs or that might be something, a bone to toss to the White House in terms of something for these alliances to do but nobody else can figure out what the hell they are doing with them, there might be something there. If we are going to do some changes that there ought to be some mechanism to allocate certain capital resources which are now randomly and poorly or are now misallocated, is that a fair concern of any of these plans?

Mr. VLADECK. I think it is a fair concern. I think it gets into a couple of related issues. One is how very expensive new technologies are going to be incorporated into the system. And, second, is the issue of the disparities in current levels of spending, current patterns of service, current Medicaid eligibility levels, all those disparities across the States which we do propose to address by convening commissions immediately upon enactment of the bill because they are so complicated and so volatile politically.

Chairman STARK. How many commissions have you served on in your lifetime?

Mr. VLADECK. I couldn't say offhand.

Chairman STARK. Could we have something a little more specific than a commission?

Mr. VLADECK. I don't, quite frankly, know how to solve the problem of interstate equities short of some very distinguished—

Chairman STARK. Certificates of need. They work pretty well in New York.

Mr. VLADECK. That works very well intrastate, but the question of what do you do about the fact that, per capita, we spend twice as much per Medicare beneficiary, adjusting for input costs in California or Florida, as we do in Montana.

Chairman STARK. Go to national rates. If you believe in the ability of the delivery system to adjust to competitiveness, they could also adjust to regulation if they are as creative—

Mr. VLADECK. I think those are issues that require considerable study and debate.

Chairman STARK. Well, I would hope, as I say, that we would look at that because all the profit hospitals in the country have closed their emergency rooms. I mean, the instinct there is to get rid of those high cost facilities, and we soon end up with a real misallocation of these capital costs, and it is a void, if you will, in every plan, and I hope that you would at least leave a section for it. Even if it doesn't have any wording in it, we will try and fill in the blanks later. Thank you very much.

Mr. McDERMOTT. Two questions.

Chairman STARK. Yes, I would be happy to yield.

Mr. McDERMOTT. Bruce, it would be helpful to me if you would lay out what you think the hospitals, the inner city hospitals will say in answer to this proposal about capital.

Mr. VLADECK. About capital?

Mr. McDERMOTT. Argue their case for me right now.

Mr. VLADECK. I think they will say that there needs to be—and there is elsewhere in the bill, not in the Medicare provisions—an authorization for a program of grants and loans for the government to enter into to strengthen and expand the infrastructure of essential access facilities in underserved inner city and rural areas.

Now, as it was originally drafted, it would help finance such capital needs for outpatient and emergency services of inner city hospitals. I don't believe it would generate financing for inpatient services, although we have been discussing whether it should be expanded to that effect. But clearly, there needs to be some form of direct or indirect Federal subsidy to support the capital needs of providers of service in underserved areas, both in inner city and rural areas, who have limited or no access to capital markets at all not solely hospitals, but community health centers, rural health centers, and other providers as well, even if they are operating at a break even or better level.

Mr. McDERMOTT. And the present system is simply a formula that every hospital gets some capital money as a percentage of their overall take from the Federal Government?

Mr. VLADECK. Well, it is a little more complicated than that because of the transition under the Medicare program. In fact, each hospital is receiving a blend of its actual capital costs and some national level, so those institutions that were very low cost in capital traditionally, like the public hospitals in New York City, for example, are actually receiving less than the hospitals that are more newly capitalized. So we do have a problem that calls for, we think, recognition of the need for some kind of grant and loan guarantee program to provide for the capital needs of those kinds of institutions. And this is included in the proposal, although again perhaps not as fully or as generously as the inner city hospital community would like.

Mr. McDERMOTT. How much money do you save between these two sections of the bill? You cut \$10.3 billion from this one. How much do you put into that pool for—

Mr. VLADECK. I don't know what the exact number is, but it is significantly less than that. About \$600 million, which I think is an annual number, floats in my head, but I wouldn't vouch for that. I will have to get you an answer to that.

Mr. McDERMOTT. So you think it is somewhere around, then, \$600 million over the course of 6 years?

Mr. VLADECK. No, I think in the peak year it is that much. It is several billion dollars over the life of the budget window, but I will have to get back to you.

Mr. McDERMOTT. I think the committee would appreciate knowing what those capital dollars are because all of our inner city hospitals are always struggling for capital, and we are going to chop them here, and the question is how little do you give back through this other section of the bill?

Having been involved in watching the block grant chop business that went on in the mid-1980s, I sort of have the feeling that we may be seeing another example of that, and it would be unfortunate if we were undercapitalizing our big city hospitals because there is no way we are going to get away from operating those, and it is simply a shifting to the State. If you don't fund it in this program, you are simply saying to the State and local government you have got to come up with the money. If that is the policy we want to set up here, we ought to be up front about it rather than do it in some kind of indirect way. Thank you.

Mr. VLADECK. Understood. Thank you.

Chairman STARK. Are there further inquiries?

If not, Bruce, thank you very much. Appreciate your testimony. We will recess for about 3 minutes and continue with Dr. Stuart Altman, the chairman of the Prospective Payment Assessment Commission and Dr. John Eisenberg, Chairman of the Physician Payment Review Commission. Thank you.

[Brief Recess.]

Chairman STARK. We will resume our hearing and welcome Stuart and John back to the committee. Your full written statements will be part of the record. Why don't you proceed to enlighten us. Stu, do you want to lead off?

STATEMENT OF STUART H. ALTMAN, PH.D., CHAIRMAN, PROSPECTIVE PAYMENT ASSESSMENT COMMISSION, ACCOMPANIED BY DONALD YOUNG, M.D., EXECUTIVE DIRECTOR

Mr. ALTMAN. Sure, thank you, Mr. Chairman.

First, let me start off with a disclaimer and I would like to follow on from Mrs. Johnson's comments in the sense that we also just received much of the new information from the administration on Thursday, so we have been busy using that information, but I would like the opportunity to revise our testimony in the next week or so as we continue to operate because some of the numbers may turn out to be quite different as we look more deeply into it.

As usual, Mr. Chairman, Don Young is accompanying me, who is the Executive Director of ProPAC.

Let me start off by some overarching statements about what we have been trying to do. Mainly what we have been doing since last week is to look at the President's plan with respect to its impact on Medicare, focusing primarily on hospitals, leaving to my colleagues to focus on physicians and outpatients, but we want to make it very clear that we do not believe that you can just look at Medicare. You really do have to look at the total impact of the President's plan on both public and private spending in order to get an appreciation for what the likely impact will be on hospitals and other facilities.

Further, we are very mindful of the fact that over the last 10 years, the Medicare program has been quite successful in holding back the rate of increase in Medicare payments to hospitals, but we are also very mindful of the fact that we have been able to do that without seeing any appreciable backlash from providers or any deterioration in quality because of the ability of hospitals to generate extra funds from other mostly private pay patients.

Now in the new—in the proposal of the President, we would have a cutback in Medicare payments, but we would also have a very tight set of limits imposed on private premiums. The good news is, as I will show you shortly, the actual compression between Medicare and private is reduced. The bad news from the hospital point of view is that the total payments would be significantly less, and, quite frankly, we don't know what implications this substantially reduced availability of funds will have on access and quality. We have modeled several alternative assumptions, and I will go through them in a minute.

With respect to Medicare spending in the President's proposal, as we understand it, Medicare spending, which had been growing at

an annual rate of about 11.1 percent, is estimated to grow at about 7.8 percent without counting in the new prescription drug benefits, and when you add that in, the growth rate rises to about 8.6 percent. So there is a substantial reduction in the rate of growth. About half of that will come from hospitals, and the other half from other payments.

Now, these other payments mainly for outpatient care, home care, skilled nursing facility care have been growing much faster than hospital care, and their growth, as we understand it, is being propelled more by volume increases than price increases. So as we begin to think about the future when you are trying to hold total spending down, if the other facility volume continues to grow and you want to keep the totals in line, it may force Medicare and particularly private payers to actually hold hospital payments to even lower rates of growth than we model.

Now the reduction in Medicare inpatient hospital payments in the past 10 years have not been matched by comparable reductions in hospital costs. As I indicated, the reason why that has been happening is because hospitals have been able to get extra revenues from other payers, so that when you look at total hospital margins, how well hospitals are doing, hospitals look like they are losing significant amounts of money from Medicare. And they are, probably on average around 10 percent, they receive probably 10 percent lower payments than their costs, but when you look overall, hospital margins today average around 4.3 percent, which is quite good in terms of historical patterns, and, by the way, I have included following my testimony 7 charts, and on that second chart you will see Medicare margins which have been substantially dropping. And on the third chart you see that the aggregate margins which are at 4.3, which have actually come up substantially since 1988 and now stand almost as high as they have been in the last 15 years except for what the hospitals would like to think of as the good old days, which is in 1984, 1985, 1986 when the PPS payments were generating significantly higher payment rates than they now are, so that total margins have been quite high, even though Medicare has been quite low.

Now the President's proposal would cover the uninsured, would cover Medicaid patients in private plans and therefore being paid at private rates, plus would be covering a variety of other patients. So we have to consider the reductions in payments from Medicare and private payers in addition to the fact that we would have this extra payment coming in from the uninsured and Medicaid now being covered by the plans.

Now when we look at the current situation—and as I indicated, the fact that many hospitals have not controlled their expenses as much as possible—we have to realize that payments from Medicare, Medicaid, and private payers are not even, and I think several of your questions of Bruce Vladeck focused on that.

Hospitals have differential ability to generate extra money, depending on what percentage of their patients are private patients, what percentage are Medicare, and the like, so if you are going to design a new payment system, you really have to look at the fairness across all hospitals, but, as I indicated, we also have to look at what the totals will look like for these hospitals and the ability

of hospitals to continue to provide the services that we have come to expect, and, as I indicated, the past is no prologue to the future. We just do not have any evidence in this country of what health care would look like if we were to bring both the private and the public payments down to the level in the President's plan.

That is not to say that we are convinced that you can't do it, but what I am saying is you can't simply look at the past and say, oh, gee, Medicare has been able to cut its payments and we haven't seen any quality reduction, why can't we do this? That is not the right way to look at it. So we have tried to model different adjustments in our efforts in terms of costs to see what might happen.

In chart 5, we took a crack at trying to estimate what the margins would look like for Medicare patients versus private patients today and what it might look like toward the end of the decade after the President's plan had been put into effect. You find some interesting numbers.

As I said, this is one of the charts that we are continuing to revise, but what it shows is that in 1991 Medicare paid on average about 88 percent of the cost of treating Medicare patients, while privately insured patients paid out 130 percent. That has become quite well known, 30 percent differential.

In the year 1999, given the proposed cuts in the President's plan under Medicare and the possibility that premiums would—private premiums would be held for the 1999 at CPI, per capita CPI, if we assume that the growth rates of all of the different sectors are about the same, it would require the payments to hospitals to go down more by private than actually the Medicare cuts such that the margins would fall for private patients from 130 to 110, and if you included all, not only privately insured, but also the uninsured and Medicaid, the margins for nonMedicare patients would fall to 103 percent, and the margins for Medicare would be 90. That, by the way, assumes that hospitals' costs are lower than they have been over this 10 year period, consistent with Mr. Thomas' comments that they are more in line with what they are today as opposed to the 10 years. So hospitals would, on average, lose on patient care, but that they would make up much of that difference from nonpatient care.

Now, I realize this may be complicated, and maybe I am not being as clear as I should be, but what I am trying to say is that if hospitals keep their costs at the lower rate which they are now generating here in 1993, and Medicare keeps its reductions in line with the President's plan, hospitals would still be able to make a profit if you include nonpatient care, but just on operating to patients they would lose money on average.

Now, let me go back and do this in a little more systematic detail, and I won't go much more than that. Over the last 10 years or so, hospitals' costs have been rising at about 4.6 percent above inflation. You can see that in chart 4. That is that straight line up.

Over the last 6 months, you were correct, Mr. Thomas, over the last 6 months hospital cost growth has fallen to 2.7 percent above inflation. We projected those two trend lines out through the year 1999. We also threw in for good measure a third possible projection, and that is suppose hospital growth in costs or expenditures didn't grow by anything more than real GDP growth, which would

be about 1.1 percent, and those are those three lines that are in chart 4.

Now, we didn't use the last one for our modeling purposes, but if we focus just on the first two, and that is using the historical period 1985 to 1992 or the most recent period, what would hospital total margins look like, and they are presented in chart 6, and what it shows is that if hospitals' costs go back to what they have been over that period, 1985 to 1992, hospitals would on average lose 9 percent where they are now making 4.3, so there is quite a swing from 4.3 to minus 9.

If, on the other hand, hospitals bring their costs down to what they have been for the last 6 months and continue that, which is 2.7 percent above inflation, then the hospital margins would only fall from 4.3 to minus 1 percent.

So the conclusion that we come to is that if hospitals can bring their costs in line with what they now have, then the total impact of the President's plan, public plus private, ought not to generate a hospital industry that is in serious financial condition.

Now, I have made no comment here by what impact the reduction in cost—in expenditures from 4.6 to 2.7 would have on quality and access, but there is evidence to suggest that they could do that without seriously affecting either of them, although you never can tell, but if they are not able to do that, then you will see a serious financial set of conditions and probably many hospitals going financially broke.

Now, in addition to focusing on total margins, we looked at other aspects of the President's plan with respect to different parts of what they now are receiving, particularly funds that they now receive for medical education and disproportionate share payments, which you talked a fair amount about with Bruce Vladeck.

As you indicated, Medicare currently has two types of medical education payments: One, the GME, graduate medical education, payment for indirect medical and the other for direct medical payments.

We focused on the indirect medical education component, and the plan suggests that the current IME would essentially disappear over time; a portion of it would be put back into these two funds that you talked about and, in addition, payments would come from private as well, that initially our best estimate, our first estimate is that the amount in total would be about the same but that over time it would grow much more slowly than the current projections; and, second, the allocation to hospitals would be quite different, could be quite different than they now are, so it would have a differential effect, depending upon which hospital qualifies under the different plans.

With respect to the disproportionate share payments, I think the same comment is clearly true, and you have talked a fair amount about changing the definition from the current definition, which is a blend of SSI and Medicaid to an SSI only, and there is no question that that would have a significant change in the allocation.

We are in the process of trying to estimate how that would change, and I am not prepared this morning to tell you how that would affect particular hospitals, but we do know that it would

change which hospitals receive it. Whether it is a better measure or not depends on what you are trying to accomplish.

Currently, the measure is designed to focus on low-income patients, Medicare, and nonMedicare. The President's plan is designed, as we understand it, to focus only on low-income Medicare, and so, therefore, the SSI makes more sense. But if it turns out that not all the uninsured get covered and we still wind up with different uninsured groups, whether they are homeless or illegal aliens, something like that, winding up in our hospitals, then maybe a broader definition beyond SSI still makes sense.

So we have tried, we will continue to work on these numbers, and make them available to you as we come up with new estimates, so at this point I would like to stop my formal testimony. Thank you very much.

Chairman STARK. Thank you.

[The prepared statement and attachments follow:]

TESTIMONY

*(Revised)*Stuart H. Altman, Ph.D.
Chairman

Prospective Payment Assessment Commission

Good Morning, Mr. Chairman. I am Stuart Altman, Chairman of the Prospective Payment Assessment Commission (ProPAC). I am accompanied this morning by Donald Young, M.D., Executive Director of ProPAC. I am pleased to be here to discuss the Medicare savings provisions in President Clinton's health care reform proposal. During my testimony, I will refer to several charts. These charts are appended to the end of my written testimony.

As you know, Mr. Chairman, the President's proposal is a comprehensive program that would provide universal health care coverage as well as fundamentally change the way health care is financed in this country. Under the proposal, most persons under age 65, including Medicaid recipients and those without health insurance, would obtain health insurance coverage through regional or corporate alliances that would negotiate with health plans to provide medical services. The President's plan also would limit health care spending by capping the growth in insurance premiums offered through the alliances.

Medicare would be retained as a separate program under the President's plan, although it would be subject to a number of cost-saving measures. These proposals seek to reduce the growth in Medicare spending for currently covered services by an estimated \$124 billion over a six-year period. Some of the savings from these initiatives would fund a new prescription drug benefit for Medicare beneficiaries.

Mr. Chairman, both the President's overall health care plan and the specific Medicare provisions will have important consequences for hospitals and other health care providers. Because it involves fundamental changes in the financing of health care services in this country, the President's plan, by its very nature, could have large effects on the delivery of health care services to all patients, including Medicare beneficiaries.

My first message, Mr. Chairman, is my most important one. The reductions in the growth of Medicare spending proposed by the President should only be considered in the context of his total proposal. Many of the reductions, such as those affecting teaching and disproportionate share hospitals, are reasonable only if the universal coverage provisions of the plan are also enacted. Further, if Medicare spending were to continue to grow more slowly than that of the private sector, then hospitals possibly could begin to discriminate against Medicare patients.

For the past 10 years, ProPAC has analyzed the impact of Medicare payment policies on the financial condition of hospitals and other providers. This morning, I would like to discuss the potential impact of spending constraints that are similar to those proposed in the President's plan and relate them to our previous findings on hospital costs and payments. Afterwards, I will discuss several of the specific Medicare measures the President proposes.

MEDICARE SPENDING

The President estimates that under current law, Medicare spending will grow at an annual rate of 11.1 percent between 1995 and the year 2000. With the reductions in his proposal, the growth rate would decline to 7.8 percent annually without the new prescription drug benefit and 8.6 percent with the benefit. Almost half of his proposed reductions, however, would come from Medicare payments to hospitals. While his proposal also would slow the growth in per unit payments for hospital outpatient, home health, and skilled nursing facility services, the more important problem in controlling Medicare spending in these areas is the rapid increase in the number of services furnished in these settings.

Mr. Chairman, the President's proposals to reduce Medicare spending for hospital inpatient care by about \$60 billion must be viewed in the context of prior reductions and hospitals' responses to those reductions. As we previously have reported to you, the Medicare prospective payment system (PPS) has been remarkably successful in slowing the growth of Medicare spending for inpatient

hospital care. As you can see in Chart 1, spending growth in other settings has also slowed, but to a much lesser degree.

The reduced growth in Medicare inpatient hospital payments was not matched by reduced growth in hospital costs. As a result, hospital aggregate operating margins for treating Medicare patients steadily declined (see Chart 2). ProPAC estimates that by the tenth year of PPS, hospital costs exceeded Medicare payments by almost 10 percent.

Despite low PPS operating margins, as well as losses from Medicaid and uncompensated care, the hospital industry generally has been able to maintain its financial position. In fact, as Chart 3 illustrates, the total hospital operating margin for treating all patients was 4.3 percent in 1991, higher than any time other than the early years of PPS.

HOSPITAL COSTS, PAYMENTS, AND HEALTH CARE REFORM

Mr. Chairman, as this information demonstrates, the Medicare program cannot be viewed separately from the rest of the health care system. The President's proposal to cover the uninsured, limit spending increases in the private sector, and slow Medicare and Medicaid spending growth will interact in ways that are difficult to predict. What is clear, however, is that the plan would slow the rate of increase in Medicare payments and curtail the ability of providers to raise revenues from other payers.

Hospitals have been able to maintain relatively high total margins by charging privately insured patients more than the costs of their care, rather than reducing their cost growth as Medicare payments were limited. In 1991, Medicare payments were \$10 billion below the cost of treating Medicare patients. In addition, hospitals sustained losses of \$5 billion from caring for Medicaid patients and \$11 billion from the costs of treating uninsured individuals. By contrast, hospital revenue from private payers exceeded costs by \$26 billion.

I should point out, Mr. Chairman, that there is considerable variation among hospitals in their ability to generate additional revenues from private payers. Hospitals with a small number of privately insured patients are especially at risk; many of these hospitals also provide a large amount of uncompensated care. PPS has assisted these special hospitals through disproportionate share and teaching payment adjustments. As I will discuss in a moment, these adjustments have helped certain vulnerable hospitals to maintain access to care for Medicare beneficiaries.

As our findings indicate, many hospitals have not slowed the growth in their expenses and their financial condition has been increasingly determined by their ability to obtain additional revenues from private payers to cover losses from government payers and the uninsured. To treat hospitals fairly, and to provide the necessary incentives to slow the overall growth in expenses, Medicare spending constraints must be accompanied by similar private payer constraints, while coverage is extended to the uninsured. But it should be understood that if hospitals lose the ability to obtain extra revenues from private patients, the pressure to reduce hospital services could adversely affect access and possibly quality of care for Medicare beneficiaries. The President's proposal, by limiting what private health plans can charge in premiums, would impose strong incentives for hospitals and other facilities to reduce their costs of providing services. How hospitals and other providers respond to this pressure will determine the impact of health care reform on patient care.

Recent evidence suggests that hospitals may have begun to constrain the rate of increase in their costs. This could be occurring because hospitals are anticipating health care reform or because financial pressures from private payers have lessened their ability to generate additional revenue. After peaking at 5.0 percent in 1992, real growth (above inflation) in hospital costs per case has dropped to 2.3 percent for the first eight months of 1993; whether this is a one-time phenomenon or the beginning of a trend is unclear.

I would like to emphasize, Mr. Chairman, that in evaluating the President's proposal, it is important to remember that spending constraints in the private sector are intended to accompany the additional payment constraints under Medicare, most notably the reduction in PPS payment updates. Interestingly, while most public attention to the President's cost containment plan has focused on Medicare cuts in spending, the PPS update factor, together with changes in the case-mix index, are likely to result in increases in per case payments to hospitals from Medicare that are somewhat higher than those received from private payers. These effects are reflected in the relative payment to cost ratios for Medicare and private patients, as seen in Chart 5. If hospitals continue to contain their costs at the 1993 rate, Medicare's payments, relative to costs, will increase from 88.4 percent in 1991 to 91.7 percent in 2000, while payments from private payers, relative to costs, will fall from 129.7 percent in 1991. Because under health reform there will be no distinction from the provider's point of view between patients who are currently privately insured and any other patient who is insured through the alliance, the payment to cost ratio in 2000 for all non-Medicare patients would be 97.5 percent.

It is important to note, however, that this analysis is based on a number of assumptions about trends in health care provision and payment, including that the health plans will allocate their premiums across providers consistent with the current distribution of health care spending. This assumption may not hold up over time because spending for hospital outpatient, home health, and nursing facility services is growing more rapidly than inpatient hospital spending.

Mr. Chairman, as we have discussed with this Subcommittee in prior hearings, the increase in the volume of services provided is the major cause of spending increases for these other facility services. If patients continue to use more of these services at current rates, prices per unit for these services would have to be severely constrained to meet the President's spending limits. If prices paid are not reduced sufficiently and the growth in services continues, the health plans would be forced to allocate an increasing share of their premiums to these alternative services and, therefore, reduce still further what they pay for hospital inpatient care. If hospital revenues were reduced, but admissions were not, per case revenue growth would drop substantially below the current cost growth and hospital margins would be much lower.

I should point out, Mr. Chairman, that while premium caps provide an incentive for health plans to constrain service volume in these non-inpatient settings, the Medicare payments to facilities generally do not incorporate similar incentives, particularly for hospital outpatient and home health services, both of which have shown substantial volume growth. While the Medicare provisions of the President's plan would reduce the growth in per service payments in these sectors, actual spending will likely continue to rise due to accelerating volume. The Medicare program may need to develop ways to control this rapidly growing volume.

POSSIBLE IMPACT OF REFORM

To understand the potential impact of the President's plan on providers, we analyzed the impact on hospital margins of differences in the growth of real (inflation-adjusted) hospital per capita costs from 1993 to 2000 under three scenarios, as seen in Chart 4:

- continuing at the average real rate from the most recent seven-year period--4.3 percent a year;
- continuing at the estimated real rate of growth for the first eight months of 1993 projected forward--2.7 percent a year; and
- equal to projected real per capita increases in Gross Domestic Product (GDP)--1.1 percent per year.

These costs are not adjusted to reflect the shifts in utilization across sites of care that are likely to occur as a result of the President's proposal. Nor does it reflect the potential effects of increased utilization of hospital services by those persons currently uninsured. I do not believe these utilization changes will have a significant effect on costs per case; they could, however, have large effects on revenues.

The analysis of the possible effects on total hospital margins is based on AHA data on hospital payments and costs by payer in 1991, inflated to 1995 using CBO's most recent projections of spending for hospital services and Medicare's hospital spending estimates. These estimates are then trended forward to 2000 reflecting the limits on private sector premium increases and Medicare spending reductions proposed by the President. We also assumed Medicaid payments at 95 percent of the amount of Medicaid spending in the base year. Since our base payments were from 1991, before the large jump in disproportionate share payments, we did not make additional adjustments for Medicaid tax, donation, and DSH policies. We also included a conservative estimate for the additional revenues hospitals would receive from covering the uninsured.

Our first analysis assumed that per capita hospital costs would grow at the same rate they were growing between 1985 and 1992, that is at 4.3 percent per year above inflation, or a total of 8.3 percent annually between 1995 and 2000. The second analysis assumed that hospitals could keep their cost growth constrained to the 1993 level, that is about 2.7 percent per capita above inflation, which would result in a total 6.7 percent total annual rate between 1995 and 2000.

As you can see in Chart 6, if costs continued to rise at the average per capita rate experienced between 1985 and 1992, the total margin would decline to -9.0 percent as the President's proposal was phased-in. Chart 7 uses the same revenue assumptions but assumes that hospitals could keep their cost growth constrained to the 1993 level, that is about 2.7 percent per year above inflation. Under this scenario, the hospital total margin would fall to -1.0 percent in 2000, sharply lower than the 4.3 percent level in 1991.

To maintain their current total margin of 4.3 percent, hospitals would have to hold their real annual per capita cost growth to about 1.6 percent. This rate has been approached only temporarily during the voluntary cost constraints of the late 1970s and the first year of Medicare's PPS.

These findings dramatically demonstrate, Mr. Chairman, that the critical factor in determining hospital financial status under health reform will be how well hospitals can control their cost growth. On the one hand, the cost constraints that will be asked of hospitals have seldom been achieved. On the other hand, they will be able to maintain their total margins at acceptable levels if they hold their cost growth to a rate that exceeds the growth in the GDP. If we are serious about controlling health care spending, we can hardly ask less.

While the charts I have presented are only illustrations, Mr. Chairman, it is clear that under the President's plan, health care providers would face stiff incentives to control their production costs. It is anticipated that the increased financial pressure would lead providers to furnish services more efficiently. The proposal's premium limits and Medicare reductions, however, would cause an unprecedented slowing in the growth of provider revenue. The extent of hospitals' ability to slow and maintain cost growth at these levels--and the resulting impact on patient care--is unknown. We are moving, Mr. Chairman, into an area in which we have little experience. It is clear, however, that we cannot rely on the lack of adverse effects from past Medicare cuts to be indicative of what will happen in response to both Medicare and private sector cost containment incentives contained in the President's proposal. We need to carefully monitor the effects of these reductions to ensure they are applied in a way that will not adversely affect access and the quality of services furnished to Medicare beneficiaries, as well as all Americans.

MEDICARE COST SAVING PROPOSALS

Mr. Chairman, I now would like to turn briefly to the specific Medicare provisions in the President's plan. As you know, in addition to the reductions in the growth rate for PPS hospital inpatient payments, the President proposes a number of specific cost saving measures for the Medicare program. These provisions would reduce the growth in Medicare spending for capital and hospital outpatient services. In addition, cost limits for skilled nursing and home health services would be reduced. As I noted previously, however, the proposal does not address the rapid increases in the number of services furnished to Medicare beneficiaries in these other facility settings.

In addition to the Medicare reductions I just mentioned, Mr. Chairman, the President also proposes major reductions to the disproportionate share (DSH) and indirect medical education (IME) payment adjustments. These reductions reflect the President's proposal to provide health care coverage to the uninsured and restructure the graduate medical education payment system, respectively. These adjustments historically have played an important role in the financial viability of some of this country's most important hospitals. I would like to briefly discuss the impact of the President's proposal.

Medical Education

Medicare currently has two types of payments that are related to medical education. The graduate medical education (GME) provision pays hospitals an amount that corresponds to Medicare's share of costs associated with operating a teaching program. The indirect medical education (IME) adjustment recognizes the higher costs of treating patients in teaching hospitals.

The President proposes eliminating GME and IME payments, after a transition; instead, Medicare would contribute to two new funds--the Health Professions Workforce Account and the Academic Health Center Account. These accounts would fund the same purposes as the payments they would replace. Both would be capped at a specified amount. Regional and corporate alliances also would contribute to the two programs through a surcharge.

Mr. Chairman, I would like to focus on the IME adjustment because it is connected most closely to patient care costs. Under the President's proposal, the additional costs of treating Medicare patients in teaching hospitals would be recognized by an allocation from the Academic Health Center Fund, rather than through a direct adjustment to hospital PPS payments. The initial allocation amount from Medicare and the alliances would be approximately equal to Medicare's current total payment amount. The allocation, however, will increase in subsequent years more slowly than Medicare's payment would have increased.

Mr. Chairman, over the last several years in our annual March Report and Recommendations to the Congress, we have recommended that the IME adjustment be reduced because our analyses show that the current adjustment overcompensates teaching hospitals for the costs associated with treating Medicare patients. We recommended, however, that any reduction be implemented gradually and its effects monitored. The President's proposal would revise the payment methodology for providing payments to these hospitals as well as sharply reduce Medicare's IME payments during the transition period. We will need to carefully monitor the impact of the reductions, as well as the potential redistribution of payments across facilities, to ensure that access to care for Medicare beneficiaries would not be compromised.

Disproportionate Share Adjustment

The Medicare disproportionate share adjustment traditionally has been used to provide additional payments to those hospitals that serve a disproportionate share of low-income patients. Currently, the measure for determining the DSH adjustment reflects care provided to low income Medicare patients, as well as Medicaid patients.

The President's proposal would revise this measure so that only those hospitals serving a disproportionate share of low-income Medicare beneficiaries would be eligible for additional payments. The President also would change the formula for determining DSH payments such that the aggregate amount of funds available for DSH hospitals would be reduced. The President believes that his plan to provide coverage for the uninsured and the resulting new source of revenue to hospitals that have furnished care to the uninsured would allow Medicare to reduce the level of the DSH adjustment.

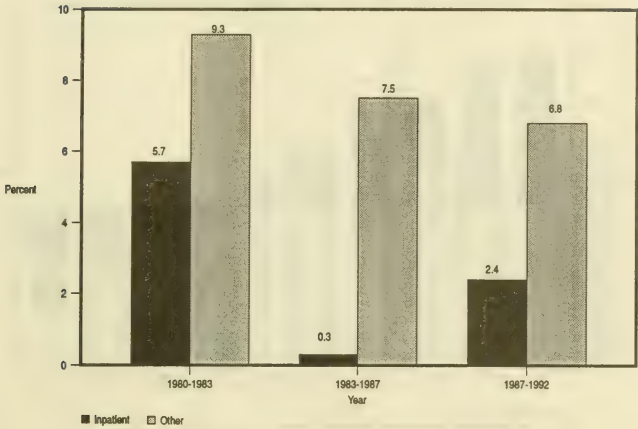
The Commission is concerned about preserving access to quality health care for Medicare patients who use hospitals that treat large number of low-income patients. The changes under the President's proposal will result in a reduction and a redistribution of the remaining DSH payments both at a facility and regional level. We are planning to analyze these redistributive effects and will report to you our findings.

CONCLUSION

Let me reiterate, Mr. Chairman, the President's proposal would fundamentally change the way health care is financed in this country. As such, the changes to the Medicare program in his proposal should be evaluated only within the context of the entire proposal.

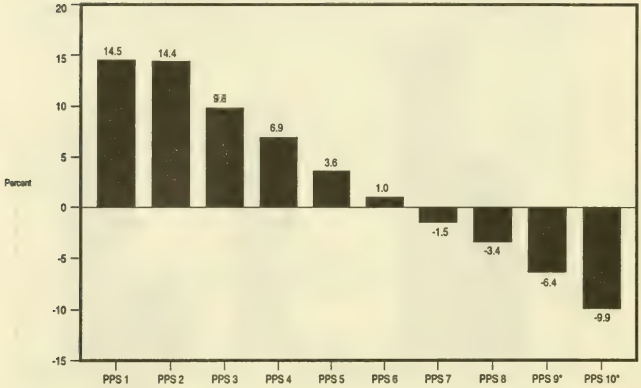
ProPAC will be pleased to continue working with this Subcommittee and the Congress as you seek to implement solutions to the problems facing America's health care system. I would be pleased to answer any questions you or other members of the Subcommittee may have.

Chart 1. Real Annual Change in Medicare Inpatient and Other Expenditures Per Enrollee, 1980-1992 (In Percent)



SOURCE: Health Care Financing Administration, Office of the Actuary.

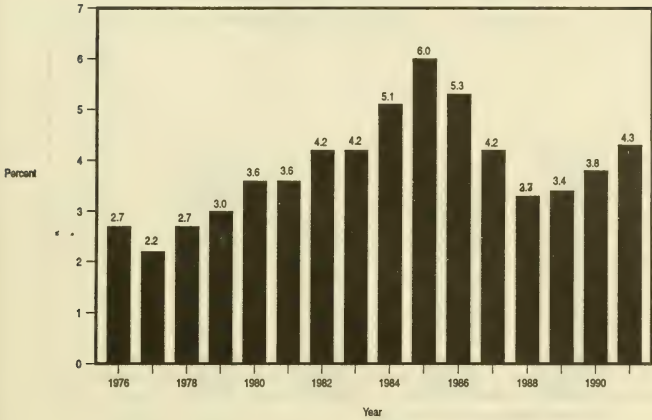
**Chart 2. Aggregate PPS Operating Margin, First 10 Years of PPS
(In Percent)**



* PPS margin estimated for PPS 9 and PPS 10.

SOURCE: Prof/MC analysis of Medicare Cost Report data from the Health Care Financing Administration.

**Chart 3. Aggregate Total Revenue Operating Margin, 1976-1991
(In Percent)**



SOURCE: American Hospital Association Annual Hospital Survey.

Chart 4. Alternative Growth Paths for Hospital Real Per Capita Cost, 1985-2000

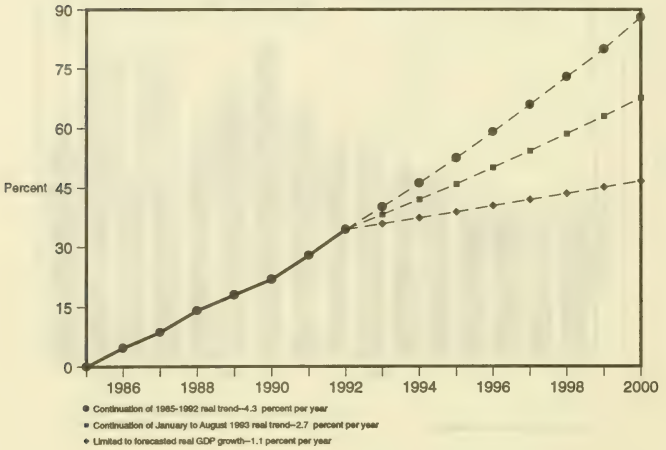
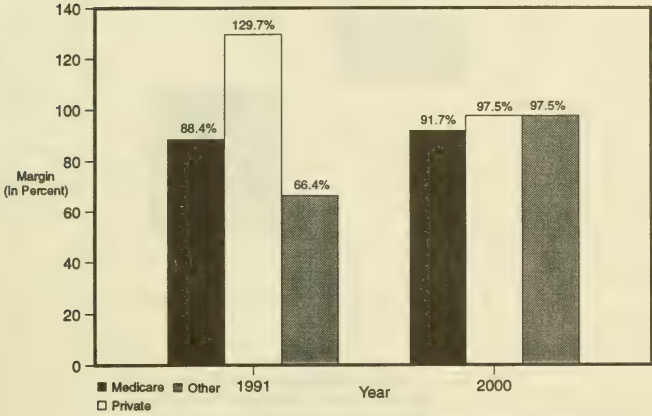
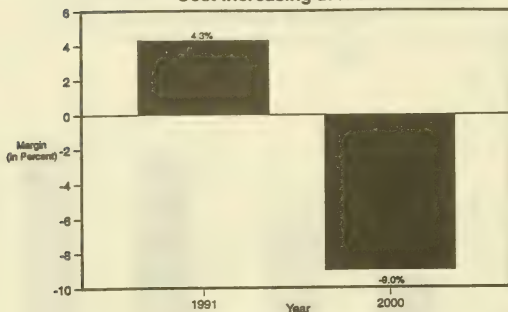


Chart 5. Hospital Payment to Cost Ratios for Medicare and Other Payers with Payment and Cost Constraints



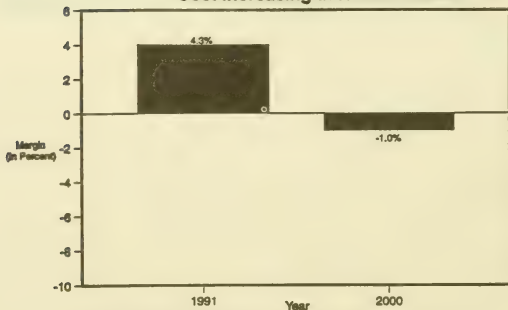
Note: 1998-2000 payment increases modeled to reflect Clinton Administration proposal; per capita cost growth assumed at 2.7 percent above inflation.

Chart 6. Hospital Total Revenue Margins with Constraints on Payment Growth and Cost Increasing at Historical Rates



Note: 1999-2000 payment increase modeled to reflect Clinton Administration proposal; per capita cost growth assumed at 4.3 percent above inflation.

Chart 7. Hospital Total Revenue Margins with Constraints on Payment Growth and Cost Increasing at Recent Rates



Note: 1999-2000 payment increase modeled to reflect Clinton Administration proposal; per capita cost growth assumed at 2.7 percent above inflation.

Chairman STARK. Dr. Eisenberg.

**STATEMENT OF JOHN M. EISENBERG, M.D., CHAIRMAN,
PHYSICIAN PAYMENT REVIEW COMMISSION, ACCOMPANIED
BY PAUL B. GINSBURG, PH.D., EXECUTIVE DIRECTOR**

Dr. EISENBERG. Thank you, Mr. Chairman. It is my pleasure to represent the Physician Payment Review Commission, and Paul Ginsburg, Executive Director of the commission, has joined me today.

We, like ProPAC and you, have not had much time to prepare based on the most recent submission of the President's legislative language, but we do feel that the Congress is well-positioned to deal with physician payment issues in Medicare because of its experience over the past several years with the Medicare fee schedule as well as with the Medicare volume performance standard (VPS).

What I will do is to focus, first, on some broad perspectives, then comment on some specific issues, including the VPS, the issue of payment for primary care, the issue of shortage areas, and the issue of constraints on extra billing.

First, with regard to the broad perspectives. We are concerned, as you are, about the growing disparity between the payment levels that are available to physicians caring for Medicare beneficiaries and those available in the private sector.

The numbers are that, as we look at them, in 1989 Medicare paid 79 percent of the Blue Cross-Blue Shield rates to physicians; in 1993 that was down to less than 70 percent, and if you compare the Medicare rates to commercial rates, it now is around 60 percent, with some services being substantially below that.

Now, the way we got there, of course, was in part through some fee reductions over the past number of years. In OBRA 90, for example, there was a reduction of 5 percent below the base line with \$15 billion in reductions in part B expenditures. In OBRA 93, there was a 4 percent further reduction below the base line, which was \$15.6 billion in reductions in part B. In addition to that, you recall that the volume offset that was implicit in the introduction of the Medicare fee schedule reduced the payment level by 6.5 percent. Experience demonstrates that it wasn't necessary since the volume offset was not as large as the Health Care Financing Administration had anticipated that it would be.

What that has left us with, then, is part B outlays going up by about 4 percent in 1992, and estimates are that in 1993 the outlay increase will also be very small.

Now, we are concerned that if there were further reductions in part B fees, and especially if there were a disparity between the Medicare part B fees and those otherwise available to physicians, that it could lead to a decrease in access of care to Medicare beneficiaries similar to that which has been documented with Medicaid. The PPRC analysis of data from 1992 and 1993 suggests that that decrease in access has not yet occurred.

We are concerned that privately insured patients could crowd out Medicare beneficiaries if that increase continues. However, we also recognize that this disparity is only partly a function of the fact that Medicare fees have decreased. It is also a function of private payers having increased payment rates to some extent over the

past few years, and so we conclude, as I think any logical individual might, that the disparity will be decreased if there is more constraint on the other payments to physicians. But we can't conclude, as ProPAC can't conclude, what the long-term effect would be if overall rates were to be decreased to physicians across the board, but we would look forward to working with you on that issue.

With regard to the Medicare volume performance standards, our experiences do help us to formulate a response to the President's proposal. For example, the recommendation that the volume performance standard be linked to gross domestic product is consistent with the way that the commission has been thinking about this issue for some time.

The idea of revising the VPS so as not to base the standard on the actual level of spending, but rather to base it on the cumulative increase from a base year, is one that we think deserves attention, and we will be looking at that.

We are concerned, though, about the recommendation that the limit on the reduction in update be eliminated. We also suggest that the Congress consider making this, in effect, a two-edged sword so that limits apply to the amount that updates could be increased, as well as decreased.

Another issue has to do with primary care payments. The PPRC's position is, and always has been, that we ought to be consistent with the basic tenets of the resource-based relative value system, and we are concerned that some of the President's proposals violate those basic principles.

For example, we believe that work values should be calculated based upon the best estimates of the work that is actually put into the service that is provided to the patient. These should not be altered on the basis of policy initiatives. Policy goals to encourage primary care should be addressed through policy initiatives that do not revise work values.

Therefore, we do not support a decrease in the office consultation rate. That is inconsistent with basic principles of the resource-based relative value scale. We would suggest, in addition, that the proposed 10 percent increase in the relative value for office visits is inconsistent with those basic principles; third, that reducing the relative work of procedures and putting that money into primary care services would be inconsistent with the basic principles of RBRVS.

The proposed increase in practice expense relative values should be based upon site—limited to office-based services. In general, resource-based practice expense varies by site of service.

The bottom line is that we believe that the principles of the RBRVS have served us well, and there are other ways, if we want to raise payment for primary care, to do so. For example, the separate performance standard, a phase in of the practice costs which would be site specific, and exempting primary care services from update reductions are reasonable ways to go.

With regard to health professional shortage areas, we are concerned that in urban HPSAs, primary care physicians are receiving one-third of the bonuses. Two-thirds of the bonuses are going to nonprimary care physicians. This is not necessarily wrong since urban residents, especially those in underserved areas need to have

access to highly specialized services. We are analyzing the President's proposal to eliminate the bonus to specialists and other nonprimary care physicians in urban HPSAs and will bring recommendations in the future.

Finally, with regard to the constraint on balance billing in Medicare, our preference has been that there be a corridor, that is, a limit on balanced billing rather than an elimination of balanced billing. The data shows that only a small proportion of services in Medicare have balance bills. Limited balance billing provides some leeway, some flexibility for physicians and for their patients and that that has been healthy. It hasn't cost a substantial amount to the beneficiary. We would recommend that the current policy be continued. Thank you.

Chairman STARK. Thank you very much.

[The prepared statement follows:]

TESTIMONY OF JOHN M. EISENBERG PHYSICIAN PAYMENT REVIEW COMMISSION

Mr. Chairman, I am pleased to come before this committee to discuss Medicare and health care reform. Since it was established by the Congress in 1986, the Physician Payment Review Commission has devoted a major portion of its work to issues related to physician payment under the Medicare program. We began by assisting the Congress in shaping the Medicare reforms enacted in 1989 and since then have been monitoring the implementation of those reforms and developing refinements in the policy.

My testimony today will focus on changes in fee-for-service Medicare to finance reform and to promote primary care. The Commission has recently begun work on the issue of enrollment of Medicare beneficiaries in regional alliance plans, and when that analysis is further along, we will be pleased to share our findings with the committee.

Medicare Cuts: Broad Perspective

The Commission has begun to combine Medicare and private sector data to determine the implications of payment changes for access to care, since the information available to date is not conclusive. The history of the last decade has been one of significant restraints on Medicare outlays played out against a backdrop of increasing fee levels paid by private insurers. The growing disparity between Medicare and private payment rates is surely one caution against further reductions in Medicare Part B spending growth through constraint on payment rates. Initiatives to reduce Medicare spending might be more successful, however, if done in tandem with changes that will restrain private sector reimbursements.

The effects of recent legislation aimed at reducing Part B expenditure growth are still being felt. The Omnibus Budget Reconciliation Act of 1990 (OBRA90) included a broad round of fee reductions in 1991, affecting almost all services other than primary care. These fee cuts and other reductions were projected to reduce Part B spending by nearly \$14 billion over the period 1991 through 1995, roughly a 5 percent reduction below baseline. OBRA93 included decreases in the default conversion factor update, fee reductions for procedures with large practice cost payments, and reductions in payments for lab tests. Projected savings from these cuts amount to \$15.6 billion over the period 1994 through 1998, or roughly a further 4 percent reduction from baseline projections.

These savings estimates do not reveal the full extent of payment rate reductions because a 50 percent "volume offset" is factored into both the Congressional Budget Office (CBO) and Health Care Financing Administration (HCFA) savings estimates. Each dollar of projected savings reflects roughly two dollars of fee reductions because CBO and HCFA assume that physicians offset half of any cuts by billing increased volumes of care to Medicare. For example, the 6.5 percent fee reduction that accompanied the introduction of the Medicare Fee Schedule was scored for no savings at all because the fee cut was to offset an expected increase in volume of care. Analysis in the Commission's 1993 report to Congress shows that the actual volume offset was significantly lower than the 50 percent, so that actual savings (and the actual impact on physicians' revenues) has been larger than projected.¹

These reductions have significantly widened the gap between the fees paid by Medicare and private insurers, both Blue Cross and Blue Shield (BCBS) plans and commercial insurers. In 1989, Medicare fees averaged 79 percent of Blue Cross and Blue Shield fees. By 1991, this had fallen to 72 percent, with BCBS fees growing 3.3 percent per year while Medicare fees fell 1.2 percent per year. By 1993, the ratio of Medicare to BCBS fees is projected to have fallen well below 70 percent. The contrast with commercial insurers is even more dramatic, with Medicare rates averaging less than 60 percent of commercial rates. Overall, we estimate that 1993 Medicare payment rates average 60-65 percent of private insurers'. The gap for specific procedures and localities is wider still.

Such large and growing differentials in payment rates raise the possibility of problems in access to care. Evidence from the Medicaid program serves as a warning that fee reductions beyond some point can interfere with access to care. The Commission is currently monitoring Medicare beneficiaries' access to care to attempt to determine where that point might be. Returns from early 1992 showed no significant deterioration in access just after introduction of the Medicare

¹ Because of this, and also reflecting an economy-wide slowing of health care expenditure growth, Medicare Part B outlays rose roughly 4 percent in 1992, versus a projected growth of more than 10 percent. Preliminary data from FY 1993 show a similarly low rate of outlay growth.

Fee Schedule. (There were, however, evident access problems for disadvantaged populations that pre-dated the recent round of reductions.) The Commission is now examining additional sources of information, including Medicare 1993 claims data, formal surveys of beneficiaries and physicians, and informal surveys of beneficiaries' complaints regarding access to care. In addition, the Commission is cooperating closely with the American Association of Retired Persons to identify areas in which Medicare beneficiaries are currently having difficulty finding a physician. The Commission plans to present findings from this research in its 1994 report to the Congress and its 1994 report on access to care, but will communicate any significant findings to the committee as these studies are completed.

While the Commission cannot draw firm conclusions on how the Administration's proposed health care reform will affect the interaction between Medicare budget reductions and access to care it can consider alternative scenarios. Private health plans will be placed under more intensive competitive pressure, and may be subject to premium caps. Alliances will negotiate fee schedules for all fee-for-service providers, probably increasing the financial stress on these providers as well.

Under one scenario, this private sector restraint may tend to crowd Medicare patients out of physicians' offices. Reduced payments may spur physicians to keep only the most remunerative private sector patients, or may encourage physicians to boost the volume of care provided to those patients, leaving less time to care for the relatively less-profitable Medicare beneficiary. However, the Medicare Volume Performance Standard (VPS) mechanism provides some degree of stabilization to this process, because Medicare fees will automatically rise if growth in the volume of care delivered to Medicare beneficiaries slows.

On the other hand, successful private sector efforts to restrain fee growth may reduce the gap between Medicare and private sector fees, lessening the financial gains from concentrating solely on private sector business. Moreover, if various types of managed care organizations lead to more efficient practice patterns, this may spill over positively into the Medicare program: the resulting lower rates of volume growth would not only benefit Medicare beneficiaries due to the increased appropriateness of care, but would, through the VPS mechanism, lead to higher Medicare fee updates.

Predicting the impact of further Medicare cuts on Medicare beneficiaries' access to care remains a challenge for the Commission and the Congress. In general, however, it seems plausible that Medicare will have an easier time constraining expenditures if that is done against a backdrop of significant constraint in the private sector. Medicare access will probably be less likely to suffer from budget cuts if such cuts are made in concert with private sector reform so that Medicare does not become an increasingly poor payer relative to the private sector. At the same time, there is the risk that further Medicare cuts can be implemented more rapidly than the private sector can respond to constraints imposed under system reform, exacerbating the imbalance between Medicare and private sector payment levels at least in the short term.

Volume Performance Standards

The Administration has proposed a series of revisions to Medicare Volume Performance Standards. One revamps the calculation of the component of the performance standard that allows for increasing volume and intensity of services. Instead of extrapolating past trends of volume and intensity growth and subtracting a performance standard factor (OBRA93 sets this to 4 percentage points for years beginning with fiscal year 1995), the proposal would base the volume and intensity component on the trend of real gross domestic product (GDP).² Another change removes actual levels of spending from the base used to calculate the annual performance standard. Instead the base would reflect previous years' performance standard factors. Finally, the limitation on how much could be subtracted from the Medicare Economic Index (MEI) under the conversion factor update default would be removed.

Although the Commission has not yet had an opportunity to discuss fully these specific changes, I can provide substantial insight into its reactions on the basis of our previous recommendations to the Congress. The Commission has used real GDP growth as a guide for establishing the

² This amount would be increased by 1.5 percentage points for primary care services.

volume and intensity component of the performance standards it has recommended to the Congress each year. The Administration's proposal is consistent with that approach. In essence, it alters the determination of performance standards from one of how much should be subtracted from the baseline growth in spending to one of how much can society afford to spend. I should note, however, that the Commission has added a factor to reflect the more rapid growth in the number of Medicare enrollees than in the general population.

From a technical perspective, changing the base used to calculate the performance standard to reflect previous years' standards appears to be sound. It would correct the deficiency of the current mechanism that has permitted actual spending (whether above or below the performance standard) to affect the performance standards for future years. This has diluted incentives somewhat and impaired the Congress' ability to budget spending for physicians' services. My tentative support for this provision is based on the explanation of the provision given to PPRC staff by HCFA officials, but not on how the provision is currently drafted in the Health Security Act.

The Commission took up the question of increasing the maximum reduction in fee updates when reviewing the President's budget proposals for fiscal year 1994. Under the default formula for updating the conversion factor, the update is determined by subtracting the difference between actual expenditure increases and the performance standard from the Medicare Economic Index. Limitations have been placed on the maximum amount that could be subtracted, however. ORBA93 increased the allowable reduction from 3.0 percentage points to 5.0 percentage points beginning in 1995. The Commission supported this change while noting that an increase over 5.0 percentage points would be too high. While it has not taken up the issue of eliminating the maximum reduction, given its previous position, the Commission may not support such a policy. The Commission also has recommended that limits on adjustments in the MEI should be symmetric -- that it would be appropriate to have the same limits on the amount that can be added to the MEI as applied to the amount that can be subtracted.

The President's plan also proposes limitations on payments for physicians' services provided by high-cost medical staffs. The Commission has just begun to examine this option and will share the results of that analysis with the committee as the work proceeds.

Promoting Primary Care

The President's health care reform proposal contains several provisions to promote primary care. They focus on increasing relative values for primary care services to further the policy objective of increasing payment for those services. Those increases would be paid for by reducing payment rates for nonprimary care services. The initial relative values for the Medicare Fee Schedule were derived from the research of Professor William Hsiao and his colleagues at Harvard University. Relative values for the work component were based on physicians' estimates of the relative work required to provide each service. Over time, HCFA has refined the relative value scale using methods, such as structured expert panels, designed to ensure that relative values reflect as accurately as possible the actual work involved in performing a service.

Retaining and strengthening the resource basis of the relative value scale ensures appropriate incentives for decisions about which services to provide to a patient, as well as acceptance by the medical profession. The integrity of the relative value scale will be even more important in the future as Medicare relative values become more broadly applicable to other payers.

For these reasons, the Commission would advise against the changes in relative values included in the President's health care reform proposal. Although designed to promote the delivery of primary care services, one of the fee schedule's principal goals, these changes would depart from the resource basis of the relative value scale and thus would undermine the credibility of the Medicare Fee Schedule. In considering this issue, the Commission recommended in its *1993 Annual Report to Congress* that changes in work values be directed towards calibrating them as closely as possible to work. Policy goals, such as encouraging primary care practice, should be effected through other mechanisms (such as bonus payments) rather than by manipulating relative values.

Beyond the Commission's general objection to changing relative values to achieve policy goals, it has specific concerns about several of the proposals included in the Administration's health reform plan. These are described in more detail below.

The plan proposes a reduction in relative values for office consultations to make them equal to those for comparable office visits. The resulting savings would be used to increase fees for all office visits. But the current average work intensities (relative value units per minute) of office consultations and office visits are already nearly identical; in fact, the Commission's past work has suggested that consultative visits should have higher work intensities than nonconsultative visits. Moreover, if the rationale is that payments for consultations are too high, it is curious why payments for hospital consultations were not similarly slated for reductions.

Second, the plan proposes increasing the relative values for office visits by 10 percent to reflect time spent before and after visits. The rationale appears to be that time spent before and after visits (so-called pre/post time) is not fully accounted for in the relative values. This is directly contrary to the Commission's conclusion, based on its visit survey, that the Hsiao study systematically over-estimated pre/post time for visits and consultations. Unless it could be demonstrated that there was a systematic error in the other direction in the Hsiao study, arbitrarily increasing office visit relative work values by 10 percent would violate the resource basis of payment.

Third, the Administration also proposes further refinement of the fee schedule by reducing relative work values of procedures for which the average work intensity differs considerably from that of services that are thought to be of comparable intensity. Using work intensities to identify overvalued services may be a useful component to the refinement process which to date has focused primarily on undervalued services. The Commission is troubled, however, by plans to apply any savings to the work component for primary care services. Again, this would further distort the relationship between primary care and other services. Use of other policies such as bonuses to enhance primary care payments could achieve the same goal while not departing from the resource basis of the fee schedule.

The Administration proposal also calls for the implementation of a resource-based methodology to determine relative values for the practice expense component of the Medicare Fee Schedule beginning in 1997. This is consistent with the Commission's recommendations to base the practice expense component of the fee schedule on resource costs. The proposal would also increase practice expense relative values for primary care services by 10 percent in 1996. While this type of transitional policy would be generally consistent with the direction of reform, some practice expense relative values would likely be raised above the levels expected under full implementation of a resource-based practice expense methodology. Moreover, because physicians do not incur all the costs of providing services in non-office settings, an approach that would increase practice expense relative values for primary care services regardless of site has a particularly troublesome potential for overpayment for services provided in nonoffice settings (for example, emergency departments; nursing homes).

Finally, the Commission has concerns that the cumulative effect of the Administration's proposals to promote primary care practice, when combined with recent policy changes, may move payments beyond what was contemplated when the Medicare payment reform was enacted. Congress has already taken a number of steps that will make primary care more attractive. These include establishing a separate performance standard for primary care, phase-in of resource-based relative values for the practice expense component of the Medicare Fee Schedule, and exemption of primary care services from general update reductions. While these steps are well advised, particularly given the higher updates for surgery in recent years threatening to undermine anticipated gains for primary care, additional efforts may tip the balance too far.

Bonus Payments in Health Professional Shortage Areas

The Administration's health reform proposal would increase the Medicare bonus payment for primary care services delivered in urban and rural health professional shortage areas (HPSAs) from 10 percent to 20 percent. It would also eliminate the bonus payment for nonprimary care services delivered in urban HPSAs.

The effectiveness of the bonus payment in providing financial incentives for practice in underserved areas and improving access to care has long been of interest to the Commission, and we are currently weighing a number of options to strengthen the program with the goal of developing recommendations for our March report. Although decisions will not be made until the Commission's December meeting, recent analysis of Medicare claims has shed new insights on the policy's performance. In rural areas, the program appears to target primary care physicians, primary care services, and physicians treating vulnerable populations. Physicians receiving bonus payments in urban HPSAs also are more likely to treat members of vulnerable populations than the typical physician in urban areas. But the bonus payments are not as well targeted in urban as in rural HPSAs; primary care physicians receive only about one-third of bonus payments and only about one-quarter of bonus payments support primary care services. A particular concern is that specialists providing hospital-based services in urban HPSAs may receive bonus payments for treating beneficiaries who live outside shortage areas.

The Administration's proposal would more effectively target the policy on primary care services. There are certain risks, however, associated with this approach. While support for primary care is essential to improving both health status and entry into the health care system, beneficiaries in urban HPSAs also have needs for surgical and specialty services. Eliminating the bonus payment for these services may detract from the program's ability to influence physician location decisions. In addition, limiting the bonus payments to primary care services as legislatively defined would eliminate nearly three-quarters of the bonus payments distributed in urban HPSAs if the bonus remained at 10 percent. Even if the limit were implemented in conjunction with an increase in the bonus to 20 percent, as contemplated in the President's proposal, primary care physicians, whose practices in urban HPSAs were found to be composed of approximately 43 percent primary care services, would receive slightly less in bonus payments than they do now.

Constraints on Extra Billing

In its design of the fee-for-service options that will be available under health care reform, the Administration has proposed that physicians not be permitted to charge above the alliance fee schedule amount. This policy would also extend to the Medicare program, which currently permits physicians to charge 15 percent above the fee schedule amount. One rationale for this proposed policy would be to ensure that Medicare beneficiaries receive the same financial protection as other patients.

The Commission considered this option in its design of Medicare physician payment reform but rejected it in favor of balance billing limits. This decision was based on a judgment that the market for physicians' services does not function well enough to preclude the need for financial protection for Medicare beneficiaries. Without such limits, the Commission feared that costs would increase and access would suffer. At the same time, the Commission viewed some allowance for balance billing as a safety valve to ensure that physicians who did not perceive Medicare fees as adequate would continue to treat Medicare patients. In addition, no matter how much care is taken in developing and refining the fee schedule, there were concerns about those instances in which prices do not precisely reflect resource costs, or where sudden changes in technology result in increased costs for a procedure that cannot be immediately incorporated into the fee schedule.

The Commission and its staff are prepared to continue to work with you on these and other issues related to health care reform. I welcome any questions you may have.

Chairman STARK. Stuart, in the written testimony today, the American Hospital Association cites a ProPAC analysis to support their argument that 60 percent of hospital costs are, in their words, beyond the control of hospitals, and they seem to be suggesting that hospitals are about as efficient as they can get.

My question is are they properly interpreting your findings and then maybe you would comment on whether they have room to cut their costs, whether simplification will save them enough money, and perhaps then lead us into the question of whether or not we would have access restrictions if the costs are too draconian. Do you want to comment on that?

Mr. ALTMAN. Well, yes. If you accept the current configuration of the hospital in terms of its mix of employees, in terms of what it does, and then you ask, well, if you are going to take that mix and trend it forward, about 43 percent of the growth comes from general inflation and about another 19 percent comes from the fact that they are treating sicker patients, so if you accept the existing structure of the hospital base, then it is true that about 60 percent of the costs are outside their control. The question is whether you should accept that core.

Hospitals over the last 40 years or more have substantially upgraded and changed the composition of their work force, much of it to the improvement of quality and access to care. There is some concern, however, that they perhaps have overdone it a little bit, faced with a fairly generous flow of funds coming at them from all sides.

And so the question before the House is whether we should accept the structure in terms of the mix of employees, in terms of the intensity of the services; so if you don't accept those, then you begin to eat into that 40 percent that is left, and you have much more room for change, and I would suspect, Mr. Thomas, that part of what we are now seeing with respect to the hospital is a structural realignment, and I would think that would continue.

Chairman STARK. You have recommended for several years that we change the policy for computing the cost sharing on hospital outpatient services to, in effect, limit the liability of a beneficiary to 20 percent rather than as high as 40 or 50 percent that result in some services just through an unintended glitch.

What is your reaction to the administration's proposal which would save the government money but basically not do anything to fix the overpayments by the beneficiaries?

Mr. ALTMAN. Well, it is true that the current structure both penalizes the beneficiaries and then splits the savings between the government and the hospitals, both do pretty well, and we have claimed it is grossly unfair and should be changed. We have been sending letters and doing anything we can.

Chairman STARK. So have my constituents, by the way.

Mr. ALTMAN. I am glad they caught on. What has bothered me personally was that no one was talking about this.

Chairman STARK. They are now.

Mr. ALTMAN. This is big bucks. We found out how big it was when we asked to change it and then OMB and CBO came up with the estimates.

Don, what were the estimates that will cost? They were more than our pay. They were big. So it is a big issue. Now, I give—

Chairman STARK. Your pay and my pay combined?

Mr. ALTMAN. No, no, not quite, but it was big.

So I think we applaud generally the administration's plan to both reduce the payments that would go to the government as well as reduce the overpayments to hospitals. I think it is moving in the right direction.

Chairman STARK. But how about the beneficiaries?

Mr. ALTMAN. The beneficiaries, Don, I think—

Chairman STARK. You want to save them money as well?

Mr. ALTMAN. Yes, I hope.

Mr. YOUNG. Originally, as I understood it, they were going to give part of it back to the beneficiaries over years into the 2000s. As I understand it now, that time that is going to be given back is beyond the visible horizon.

Chairman STARK. My beneficiaries don't even buy green bananas. When you talk about 2000, that gets beyond their—

Mr. YOUNG. Fixing the formula will, however, remove the incentive that hospitals have now for increasing their charges, so at least what we are seeing may stop growing, but it won't come down until you get back to them.

Chairman STARK. We appreciate your getting into that because it has got to get fixed.

Mr. ALTMAN. Yes.

Chairman STARK. It is a glitch.

Mr. ALTMAN. And also it discriminates against people that go to get their outpatient care in a hospital versus a clinic. It really distorts the delivery system in a way that may or may not be medically appropriate. We ought to be treating the same services the same regardless of what facility is providing it.

Chairman STARK. I agree. Mr. Thomas.

Mr. THOMAS. Thank you, Mr. Chairman.

Thank you folks. You are going to be a lifeline to the surface as we get into trying to analyze what folks are telling us we should do, what we think we can do, and in the process of change, trying to hang on to what we thought we were doing that was good and we may want to continue to do. Dr. Eisenberg, I guess that is a direct statement in regard to your comparison of what the Clinton plan wants us to do versus what we had laid out in terms of the RBRVS changes on the basic principles.

Have you been able to reduce it in the savings differential? In other words, if we hung on to what we wanted to do versus the changes that were made and the difference between the two in an actual dollars and cents situation, what is the result, or is that not possible?

Dr. EISENBERG. You mean, to project it forward?

Mr. THOMAS. Yes. Look at the question of whether or not we change what we thought was right because the savings are so great versus if we are not going to make very much money on it, why are we doing it.

Dr. EISENBERG. Right. Let me answer in this way. First, the budgetary controls in the 1989 OBRA really were more on the Medicare volume performance standard side, not on the RBRVS side.

The RBRVS itself was budget neutral, so what we need to do is focus on the MVPS.

Our sense has been that the decrease in the volume of services rendered and the relative decrease in total expenditures is a bright side. We are encouraged by it, but we recognize that it is in large part a function of the reduced fees which were legislated, and now that we had an over reduction in fees, in our opinion, we have come up with an increase in fees that will compensate to some extent for that, as was stated earlier with the surgical services.

Now, for 2 years we have had a slowing in the growth of total expenditures on part B, and, as I said, that is a bright sign. We are not sure that it is sustainable. We believe that the Medicare volume performance standard provides us a mechanism whereby we can be sure that some limit on growth is sustainable, but I would not personally anticipate that the reductions in the years to come will be as dramatic as they have in the years past because of the dramatic reductions in fees during those past few years.

Paul may want to add something.

Mr. GINSBURG. I just want to add one thing. As far as the President's proposal to restructure the relative values in order to give something to primary care, that part of this proposal apparently is not a saver, it is budget-neutral. It seems strange that it appears in a list of budget reductions because it is really quite different.

Mr. THOMAS. Dr. Altman, in terms of your charts, I will ask you some questions to which I do not know the answer.

I think that is the purpose of these sorts of things in terms of how we handle this, because the argument has been on kind of a teeter totter. You have got the cost savings and you have got the choice in quality over here. Access I put in the choice and quality part of it, and then you are projecting forward trend lines which we have got to do more of to give us some kind of a guideline on where we are.

Let me ask this question to get into it: The discussion now with the President's plan in terms of the requirement for a State to pick up the Medicare folk within the alliance structure, requires you to pick them all up rather than any kind of a selective process. Built into the comparison chart, did you assume all of Medicare would be picked up in a State, or would that have any difference at all in terms of the shifts in the future?

Mr. ALTMAN. I don't think it would matter. In our modeling effort, we assumed that Medicare would continue to function just the way it is, and that the payments would be derived from Medicare separately than private.

Mr. THOMAS. OK. In the President's benefit package, and looking at hospital usage in terms of the basic benefits package; are the hospital benefits so core and plain vanilla that an examination of the generosity of the benefits package or a reduction of benefits is not possible? Would that have any significance in the trend lines in the charts?

Mr. ALTMAN. The benefits, as I understand them, are pretty much the same. What is different is the cost sharing. Now, to the extent that the cost sharing, the deductible, the long—particularly for patients that are in the hospital for a very long time affects utilization, there may be a slight differential in utilization.

Let me put it the other way around. If the Medicare benefits were changed to the private, there might be a slight increase in utilization, but I think it is going to be very small.

Don, would you—

Mr. THOMAS. OK, on chart 5, when you talked about the relative cost differences, in 1999 you assume, I think, and I want to make sure this is true, that you have picked up everybody that is out there. I think you left out the qualifier, illegal aliens, or some other factor since the President doesn't pick that up, but basically you have picked up everybody.

Mr. ALTMAN. Yes.

Mr. THOMAS. In 1999.

Mr. ALTMAN. But I want to emphasize something in this chart because I don't want the false impression to come about. In 1991, we have people coming into the hospital with different tags on them, if you will excuse the expression, and when somebody comes in with a private insurance policy for the most part they are paying on average 30 percent more than the cost. If they come in with a Medicaid tag on, on average they are paying 80 percent of the cost, so 20 percent below, and if they are uninsured they might, the hospitals might on average pick up 20 percent or something like that.

In 1999, when Medicaid recipients and the uninsured are now all incorporated in the private plan, the average payment, and you could not—a hospital cannot tell the difference, there is no tag associated with them. The average differential between what the hospital will be paid and their costs will not even be the 110 percent that I have here, but 103 percent. The 110 percent has tried to just look at private, if the private had stayed separately tagged so that the drop is actually more significant, more significant for the private.

But if I had included in 1991 not only the private but the Medicaid and the uninsured, that rate would have been like 108 percent of costs. So what has happened from the hospitals' point of view, it has gone from 8 percent above to 3 percent above.

Mr. THOMAS. OK. Then finally chart 6, which is my real fear in the question about whether recent changes are in fact structural or whether they are temporary. If you are telling us that the choice between historical and current is a 1 percent drop from 4.3 to the 3 percent profit range, I am not concerned. If you are telling me, in fact, that we can't count on that and the historic trends are closer to it, we wind up with an inverted position of 7 or 8 percent, and that is a pretty big risk factor.

Mr. ALTMAN. And it could, when we finish our estimates, the gap may even be wider.

Mr. THOMAS. Wider. Thanks.

Mr. ALTMAN. And it is a big risk factor, but I am sort of closer—I almost hate to say this because it is inconsistent with my previous position, but I am almost closer to where you are in the sense that I do believe that the medical care system is going through a structural change, that it is not going to bounce back so easily to the 4 to 6 percent above inflation increases. I don't think it is going to hold. It may not hold to the 2.7 percent because that is a combination of those two things that you brought up earlier.

Mr. THOMAS. But it doesn't have to stay at 2.7, it has just got to stay below, if it is at 4 percent.

Mr. ALTMAN. But as you can see, as you begin to move from 2.7 to 4.6 percent, those numbers become very sensitive.

Mr. THOMAS. Thank you.

Chairman STARK. Mr. McDermott.

Mr. McDERMOTT. Thank you, Mr. Chairman.

Mr. Altman, let's talk about the structural change you are talking about because as I look out on the medical care system that I know, it seems to be in a great deal of chaos and an enormous amount of turmoil, and I wonder in your projections for the future what kinds of assumptions you have made about costs in hospitals with respect to employment costs and the purchase of physicians' practices.

In the city of Seattle, I know several hospitals have purchased as many as 200 doctors' practices, bought the capital of the various practices. I also know that hospitals are laying off large numbers of nurses. Now, in part, apparently, because of a drop in occupancy, but also because there is an increasing trend in the delivery of care at the bedside to go to technicians rather than to nurses, and I wonder, are you using simply the old lines and just carrying them out or are you making assumptions about the reduction in employment costs in dropping from a \$25-an-hour nurse to a \$10-an-hour technician who is working at the bedside?

Mr. ALTMAN. Well, first let me say that I am aware of what you are saying, there is a lot of turmoil, confusion. As I said, I think the health care industry is going through some fairly major structural changes. We could not estimate that level of detail in our models, so instead what we tried to do is to bracket it. It is a statistical, I wouldn't say it is a trick because we really don't know the full impact of where this is going to finally lead. That is why we gave three estimates of a cost growth: One the high side and that is costs continue to grow at those old historical levels; two is the last—

Mr. McDERMOTT. That is graph 4, essentially?

Mr. ALTMAN. Right. That is then what would happen if the current rates continue. And then we also estimated what might happen if costs were only to grow by that 1.1, but we can't pinpoint exactly what hospitals will do or in fact are doing in that, but we do feel comfortable that within those three estimates you have a bracketed likelihood.

And then you need to look at them, at each one separately, but I want to make one thing—I want to reemphasize something I said before. Much of this is happening without reform.

Mr. McDERMOTT. Yes, I am quite well aware of that.

Mr. ALTMAN. And it will continue to happen.

Mr. McDERMOTT. Yes.

Mr. ALTMAN. I do believe we are seeing a fundamental change that is not a halo effect of a—simply a possibility of reform. There are real budget pressures being placed on these institutions that are not just anticipatory.

Mr. McDERMOTT. Now, it is conceivable, however, that under this process you could have a situation where the more aggressive a hospital was in driving down their labor costs, the more likely

they would under your prospective payment system accumulate considerable capital. Is that fair?

Mr. ALTMAN. You mean to the extent that they drive their costs significantly below what their payments are, they could generate higher amounts of money? That is possible. The more likely scenario in a not-for-profit institution in particular is their costs usually go down after the revenues go down, not before—it is unlikely to see costs continue to fall faster than revenue because, let's face it, reducing costs long term is a tough game, and so I think it is more likely the other way around, but it is possible, sure it is possible.

Mr. McDERMOTT. It seems to me the hospital industry, at least the assertion made by the nurses, and I am really sorry we don't have the American Nursing Association here to testify on this whole business. Their assertion is that what hospitals are now doing is trying to get rid of all the nurses as quickly as possible, and therefore accumulating reserves so that going into the national health plan they will have built up a sizable amount of reserves for whatever purpose they then decide to use them.

Mr. ALTMAN. Well, as someone who has just been in the hospital recently, I sure hope they don't do away with all the nurses. That is where all the good care came from. So I hope that is not the case, and it is possible. I am sure that they are going to bring you examples of where that is happening, and it may make good long-term financial sense, it may not make such good patient care sense.

Mr. McDERMOTT. Well, that is precisely my concern, is the quality of care suffering as a response to anticipating what the national health plan is actually going to look like and do to them, particularly when we talk about the issue of capital.

You heard Mr. Vladeck's testimony, I think, on capital. Can you comment on that, what you think is going to happen to hospitals in terms of their capital ability, ability to accumulate capital and build?

Mr. ALTMAN. Well, this business of accumulating capital could be a temporary phenomena. To the extent that you are putting money away for a rainy day and it does rain then they are going to need it. But to the extent that they put it away and never use it, they will generate fairly substantial reserves and we have institutions that I know of that have substantial amounts of reserves.

In general, I would say, as Mr. Stark has pointed out, one of the aspects of our health care system that is driving so many of our costs is this overcapitalized system and I would think quite the opposite will happen. If these premium controls—forget about Medicare—if these premium controls are put into effect at the levels we are talking about, they are not going to be able to accumulate capital so fast.

Quite the opposite. They will be squeezed, and some institutions much more than others. I am less concerned about extra capital. I am concerned about the fact that we may need to pull capital out of the system faster than the market will.

Mr. McDERMOTT. Some of us share that same thing.

Dr. Eisenberg, a couple of questions about your testimony. You suggested that we should not change the relative values but rather make bonus payments. The whole concept of the President's plan

is that we are going to have more primary care and clearly there aren't enough doctors out there to do that right now so they are trying through a financial incentive system to drive physicians into delivering primary care rather than delivering more specialty care. You talk about this bonus business.

What kind of bonus do you think we should make? We went through a lot of trouble to try and put the relative value scale together and to then start fiddling with it as you suggest for policy reasons rather than on a resource basis that was alleged to have been used, has some downside to it. I would like to hear you talk more about that.

Dr. EISENBERG. We would prefer as a commission that we stick with the basic principles of the RBRVS. There are changes that we believe are needed in the fee schedule that would move us closer to the principles of RBRVS without having to need to apply bonuses to encourage people to go into the primary care field.

The update for example; the process of updates needs to be reformed. Second, the practice costs payment need to be reformed and those alone will make a substantial contribution.

My comment about bonuses was to suggest that if we believe that those changes are not sufficient and that more of an incentive is needed, we would rather see targeted bonuses than changing the basic system of RBRVS.

One example concerns those areas that are underserved, urban or rural, where we believe that a bonus payment is necessary to encourage physicians to practice. That would be a way in which the bonus could be used. There may be other targeted areas where a bonus might be necessary, but we prefer that to fiddling with the RBRVS basic mechanism.

Mr. McDERMOTT. It is not your view that this can be relatively neutral. From a fiscal standpoint, there needs to be an additional infusion of money rather than taking it from the haves and giving it to the have-nots. That is not going to work.

Dr. EISENBERG. I believe that the level playing field which the RBRVS seeks will be sufficient to allow physicians to make a decision that is not influenced by their future income about where they are going to practice and what they are going to do. In the meantime, it may be necessary to have some of these bonuses, for example, the bonus to get physicians to go into underserved areas because we have not yet corrected for the different practice costs that are incurred by a primary physician in a rural area compared to one in a suburban area.

I see these bonuses as stopgaps until we get to the point when the RBRVS is fully implemented. Then I think that ought to be sufficient.

Mr. McDERMOTT. At what point do you expect the RBRVS to be fully implemented?

Dr. EISENBERG. On the work side, it will be fully implemented in 1996, but on the practice cost side, you haven't made a decision about exactly how we will implement the practice costs introduction and what the methodology will be for determining what the change in the practice cost payment will be. I would say late 1990s at the earliest is when we would have it fully implemented to get both those components in place.

Mr. McDERMOTT. Say more specifically what our part is that is left to decide, why it costs more in New York City than in Dayton Ohio, that kind of thing.

Dr. EISENBERG. That is one issue, but the more fundamental question is how much it costs to practice one type of medicine versus another. One is hospital based. One site has the need perhaps for more infrastructure support systems than the other has and that hasn't been worked out yet.

Mr. McDERMOTT. Has that been worked out anywhere in the world?

Dr. EISENBERG. We have models. I don't think there is anywhere in the world where it has been completely worked out.

Mr. GINSBURG. In most of the countries that have fee schedules, the relative value scale is negotiated within the medical profession. We seem to be the pioneers in trying to get data to construct a relative value scale.

I would say that we are fairly far along the road to having resource-based practice expense. The provision in OBRA 93 you just enacted makes a number of reductions for services. We see the provision as a fairly accurate transition toward resource-based practice expense. It is just that the legislation did not go the final step of actually mandating that the system be used say in 1997. I understand there is a lot of discussion around technical amendments to accomplish this.

When I get outside of Washington, often I hear the impression that we really haven't favored primary care, haven't changed the balance. But actually the implementation of the RBRVS is going very much according to plan and that in relative terms the degree to which we have improved payments for evaluation and management services and decreased payments for procedures is going very much as projected.

In OBRA 93 you took a number of steps akin to bonuses for primary care, for instance the reductions in the updates. You went lighter on primary care services than on others. We are doing some simulations to try to cumulate all the changes that Congress has made since the passage of the RBRVS that affect the balance between primary care versus other services and a lot appears to have been done.

Dr. EISENBERG. One way to think about the practice cost process is we are now very much like we were when we were reducing overvalued services before OBRA 89. We know there are certain practice expense relative values that are highly likely to be overpriced. OBRA 93 basically applies a screen where the practice costs above a certain percentage were reduced.

Mr. GINSBURG. The screen was a percentage of the work values, so that when the practice expense value exceeds that screen, it is reduced in a series of steps through 1996. We felt that this screen for nonoffice-based services was very close to the methodology that we had put forward for those services and we are very pleased that the Congress focused the policy on the nonoffice-based services and left the office-based services for when there is more data available.

Mr. McDERMOTT. From a doctor's standpoint, wouldn't it make more sense to have it simply be a negotiation rather than doing it on some abstract basis of data gathered?

Dr. EISENBERG. We discussed the process in negotiation as a commission and there are a number of issues that we are uncomfortable with at this point. One is who represents the physician.

Another is that there in fact are substantial differences across groups of physicians in different regions of the country that don't necessarily honor state boundaries or national professional society definitions. One problem is the absence of a mechanism for negotiation.

Mr. McDERMOTT. In the President's plan where he anticipates that it will be done State by State by State, doesn't that answer the major objection you have just raised, that that cuts across the difference between New Jersey and New Mexico?

Dr. EISENBERG. There are two issues. One is that much of the calculus that you refer to had to do with the relative weight of each service compared to the other. The negotiation then could occur over the conversion factor.

Mr. McDERMOTT. Yes.

Dr. EISENBERG. We believe that the continued calculation of what the appropriate relative weight of each service is ought to be continued. That is what we were just addressing. That is the payment for the different work elements. When we get to the conversion factor, in effect what you are doing is deciding how much the service is worth, not so much what the relative costs of each service is.

If you decide that 30-plus dollars is what you will pay, then still the distribution across specialties and across services will remain the same.

Mr. McDERMOTT. That is basically the German system. The Germans negotiate on the basis of the local sickness fund, whether it is in Hessa or Westfalia or wherever it is done on that local basis. The relative value is not the issue, it is how many fennig per unit. You are saying if you get the value scale set then you can negotiate how many pennies you are going to pay for any given item.

Dr. EISENBERG. You could. We have been struck by the number of countries who have come to look at RBRVS as a model for deciding what the relative distribution among the services would be, still leaving the debate about the total expenditures or the conversion factor to negotiation. But in many ways where you decide what the update is going to be for the MVPS you are in effect negotiating.

In this case, we have Congress making the decision rather than negotiations between physicians and some other party. Since the total expenditures are determined and then the relative values are established per service, it is simply a matter of dividing the total budget by the amount of services rendered to come up with what the conversion could or ought to be.

Therefore whether you start by negotiating the conversion factor or you negotiate what the total expenditures are going to be, in effect you come to the same place.

Mr. McDERMOTT. Thank you very much.

Chairman STARK. Paul, you said something about a problem in calculating practice overhead costs? Is that what I heard you say?

Mr. GINSBURG. I don't think there is a problem.

Chairman STARK. It is a lot easier than the professional side, isn't it?

Mr. GINSBURG. Yes. I think it is easier.

Chairman STARK. It is cost accounting?

Mr. GINSBURG. Yes.

Chairman STARK. You don't have to be an M.D. to do that; a CPA, right?

Mr. GINSBURG. That is correct.

Chairman STARK. So we can get that done. Doctors won't like it in some cases because CPA's are difficult people to get to make value judgments, to make accurate judgments on. They just count and divide and multiply and things like that.

Mr. GINSBURG. Yes, it is sometimes because they need information, but they are basically trying to estimate what is the cost of supplies, how many hours of labor of different types goes into a service.

Chairman STARK. How many square feet, how much heat?

Mr. GINSBURG. That is right.

Dr. EISENBERG. There are plenty of physicians who hire accountants to come in and tell them how their practice is running. It is a matter of who the accountant is working for.

Chairman STARK. The idea that if you could do a procedure in a 10-by-12 room without a window that doesn't take any particular equipment, you say we have to have more money because we do the procedure in some Taj Mahal of a hospital, it is nicer to do it there but—

Dr. EISENBERG. That is one of the problematic issues with the interspecialty practice costs. If a psychiatrist has a certain kind of office because that is the kind of office he can afford and another kind of physician has a fancier office because he can afford that office, then if we use totally historical expenditures locked into what the physician's historical revenue has been, we may end up locking ourselves into these differential styles of practice to which you allude.

Chairman STARK. I understand it isn't simple. It is in fact much more of an empirical study and will take some time to get done.

I concur with Congressman McDermott's theory that I am very reluctant to fuss around with the resource base relative value, which we didn't negotiate, you guys did or the doctors did, and I think when we start using that for us to save money or reward people we would be inclined to screw up the whole system and we should stay with bonuses, which I think you suggest Dr. Eisenberg in your testimony.

Dr. EISENBERG. I agree.

Chairman STARK. I do too. The question you raise—and I just want to conclude with this—is that you seem to suggest in your testimony that the difference in the Medicare rates and say Blue Cross rates are diverging, growing wider.

Wouldn't that suggest to you that, and maybe you have some figures on areas—if in fact the divergence was growing as rapidly or more so say in the San Francisco Bay area, as compared to say South Carolina, wouldn't that indicate that managed care isn't doing much?

In the Bay area where you have 70 or 80 percent of the people in a variety of managed care plans and in South Carolina where you have 3 percent in managed care plans, if your figures would

show that the divergence between private pay is just as big in the Bay area, if not bigger than as it is in South Carolina, would it be a reasonable conclusion to say managed care isn't doing much?

Dr. EISENBERG. Not necessarily. First we don't have that data to present today.

Chairman STARK. Let's assume it.

Dr. EISENBERG. One alternative explanation of the scenario you present is that the fee differences were wider in certain areas because the volumes were so different. For example, if I am in a managed care organization in a certain area and I keep the volume down I could be paid a higher fee—

Chairman STARK. Are you talking about aggregate costs?

Dr. EISENBERG. If you compare fee to fee.

Chairman STARK. Let's just take the Bay area. We are talking about fee and the growth, how they change. So the relative fees are irrelevant. We are just talking about how wide the spread between Medicare's fee and private fee.

Dr. EISENBERG. Right.

Chairman STARK. Now, if in an area where there is as big a difference, and I believe it is 70 or 80 percent of the people in the 2 or 3 SMA's around the San Francisco Bay area are 70 or 80 percent in managed care programs and I know that less than 4 percent of the people in the whole State of South Carolina are in them, if the divergence between what Medicare reimburses and what private insurers of plans charge is growing faster in the Bay area than it is in South Carolina, would you begin to think that maybe the managed care isn't doing much?

Dr. EISENBERG. You mean the fee that is paid per service?

Chairman STARK. Yes.

Dr. EISENBERG. That would be one reasonable conclusion, but another is the one I would suggest may be just as likely. If in the Bay area the physicians are performing a lower volume of services, then the managed care organizations can afford to pay them a higher fee for those services that they are providing. So, if I am a doctor, I talk with my managed care organization and I say I can hold volume down but I want you to pay me a higher fee to begin with.

Chairman STARK. You are saying the doctor was a crook in the first place because he was doing too many procedures the year before. So then he goes back to the gatekeeper and says "I will only do half as many procedures, and those poor guys who miss out I ain't going to do it for," that might happen.

Dr. EISENBERG. I don't think you need to impugn that he is a crook to do that. The whole concept of managed care is that you provide incentives or mechanisms for physicians to reduce the volume of certain services. It may be to do less or to change the venue of the service. They may move them out of the hospital into an ambulatory center, they may provide home care instead of nursing home care; they may change the nature of the services.

Chairman STARK. You are saying then the doctor is very volume sensitive so if he is making \$500,000 a year, he will do everything he can to keep that level of reimbursement; right?

Dr. EISENBERG. The work that we have done and others have done based upon the fee changes that have occurred in the past few years suggest that doctors are fee sensitive and that induced de-

mand probably does exist; not as much as HCFA thought it might, but it does exist.

Mr. ALTMAN. Mr. Chairman, let me—at the expense of jumping on to the other side issue—bring up the fact that we are going to have to at some point stop splitting outpatient and physician and inpatient particularly when you talk about private premium controls and their implications, because if you are talking about holding total premiums under fairly tight limits and maybe holding Medicare within that as well, and the hospital side levels off in terms of the continued drop in utilization, you are going to have to see a very sizable change in the outpatient side, since the outpatient side both on needs and utilization has benefitted tremendously by being under a declining inpatient use so that the totals weren't looking nearly as bad as they could have if both had been increasing.

The inpatient side is leveling off now. We are down to lengths of stay—Germany, our lengths of stay are 50 percent of the Germans.

Chairman STARK. In Germany it is \$300 a day for any procedure, removing a plantar's wart or transplanting a heart. My God, the costs are so much lower there.

Mr. ALTMAN. I am not suggesting—they also don't have—they could benefit from more skilled nursing facilities. Even within the same DRG, from what we have been able to see, their lengths of stay are higher and they use their hospitals more than we do.

Not only do we need to look at Medicare versus total and look at the total for inpatient, but we also need to look at total spending, because our estimates that we have given suggest sorts of sector budgets, but the whole essence of the administration plan is they won't have sector budgets, they are going to have total premium limits.

Chairman STARK. I don't think that will work, do you?

Mr. ALTMAN. It will be a new experiment. No country has ever done it, but it has some theoretical appeal.

Chairman STARK. OK. Just another idea—I have just received a letter from the Majority Leader suggesting what I should do—I can read it in mixed company—over the holidays to sell this plan. I thought I would end this panel—go ahead.

Mr. McDERMOTT. Before we terminate this panel, I would like to ask one question of Dr. Altman. You previously testified before the committee you did not believe it was possible to impose a global budget at its ultimate cap in one step, that we would need to phase it in GDP plus 4, plus 3, plus 2, plus 1 et cetera.

Do you still believe that?

Mr. ALTMAN. I am sure I said that, but I am willing to also be—I am a professor. I can change my mind. It would be better if you phase it in. Clearly our ability for institutions to sort of grapple with the level of reductions in payments, it makes sense to do it over time.

You could for a short period of time freeze payments given the level of this industry and not see catastrophic implications, but I think the more important issue is what is the long term sustainable growth rate that we want to have, and that is a very open issue and we had that discussion.

Where do we want the long-term growth—you could phase it in sharply but do we want to bring it down to essentially no real growth—CPI, they are talking about CPI plus a few percentage. Most countries bring it down to kind of like GDP plus, a few percent. That is going to be the issue that is going to be ultimately before the House, what is the long-term growth spending we want this country to be at?

Mr. McDERMOTT. Do you think GDP plus 1 is attainable, Dr. Altman?

Mr. ALTMAN. I think it is a much more attainable level than CPI or CPI plus 1. It is not without its pain particularly—GDP plus 1 is relatively easy for the hospitals but if you have sector budgets and they have to go to GDP plus 1 that will be tough, particularly when you get home care and prescription drugs you are talking about big growth items, new technology coming online.

It is going to be hard sector by sector to deal with that and that is why premium controls have certain appeal, because they don't force you into boxes.

Mr. McDERMOTT. They essentially put all the money in one bag and let the system sort out where it ought to go?

Mr. ALTMAN. Right. Theoretically to me that has more appeal, but I would have to say that no country in the world has chosen to go that route.

Mr. McDERMOTT. Why haven't they?

Mr. ALTMAN. The other is simpler. The Germans have a totally different payment system for physician services and hospital care. The same is true in Canada and Australia, and in every other country that I have looked at. They have different traditions, different groups that focus on it. They don't have premiums for one thing. They have different spigots so they just deal with each one separately sort of like the way we do part A and part B.

Mr. McDERMOTT. There is no theoretical reason why our way is better or worse?

Mr. ALTMAN. I think the premium controls theoretically are better, gives the delivery system more flexibility, but it is harder.

Mr. GINSBURG. The premium limits are an idea for a system where a large portion of the population is served by managed care plans.

Chairman STARK. Isn't that what we do in Medicare now? For risk contracts, we have a premium.

Mr. GINSBURG. But most beneficiaries have not enrolled in a risk-contracted plan.

Dr. EISENBERG. The PPRC has dealt with the issue whether the GDP plus 1 or whether the CPI is the right number. The general sense, although we haven't come to an explicit conclusion, is that the GDP is a reasonable number to use as a goal to guide our other decisions.

There is concern that it may not provide this country as much room as it wants to add new technology. There are others though who would argue that we can reduce unnecessary services and get the new technology through those savings, but without a doubt, I think people feel that over time, it is a better goal than CPI, and it is a reasonable goal to keep in mind.

Mr. McDERMOTT. Thank you, Mr. Chairman. You can read your letter now.

Chairman STARK. It is a suggestion how we sell the President's plan. We should go to a hospital on Thanksgiving, set up a table in The Mall.

That book describes in great detail the President's plan, but it does raise a question and one of the problems I have had—let me ask Dr. Eisenberg—you are familiar with George Washington Hospital? You work there?

Dr. EISENBERG. I work at Georgetown.

Chairman STARK. You have two separate records rooms, one for insurance payments and collecting money and another for medical records for patients?

Dr. EISENBERG. We have multiple of each, in fact.

Chairman STARK. I mean they are separate.

Dr. EISENBERG. Yes.

Chairman STARK. You don't keep the medical records in with the insurance payment records; is that correct?

Dr. EISENBERG. That is correct.

Chairman STARK. Do physicians get involved with the payment records and the insurance records very often or are they involved with the patient's medical records?

Dr. EISENBERG. Physicians, both in a large university like the one where I work and even more so in a practice where it is more of a——

Chairman STARK. I am just talking about Georgetown Hospital.

Dr. EISENBERG. Physicians get involved more on the physician billing side, but they get involved with both when the patient can't pay and the question is what are we going to do about this individual. The hospital says "Do you know something about this person? Did he just lose his job?"——

Chairman STARK. For the most part, physicians deal with the medical records.

Dr. EISENBERG. For the most part.

Chairman STARK. Do nurses deal with the medical records side?

Dr. EISENBERG. Yes.

Chairman STARK. And the admitting and billing people deal with the other side?

Dr. EISENBERG. Generally.

Chairman STARK. How much would you guess in Georgetown Hospital of the medical records kept for patients would you classify as unnecessary and useless?

Dr. EISENBERG. Of the records which are stored, the medical records, in fact we only keep on site the records for the past 18 months.

Chairman STARK. No, when I am there——

Dr. EISENBERG. You mean services rendered, how many are unnecessary?

Chairman STARK. How many of the records that you take when you take somebody's pulse or blood, the medical records, how many of those, what percentage of those would you guess at Georgetown are unnecessary?

Dr. EISENBERG. It is a difficult answer because they are necessary for different reasons. If we had no fear of malpractice and

therefore we didn't think we needed to keep as exhaustive a record as we do to document the care and the rationale for the record that was provided, I would guess that we could prune the chart to half or a third of what it currently is.

Chairman STARK. So you think that half of those medical records are there to defend the physician against some legal action?

Dr. EISENBERG. A substantial part, yes. I would guess about that amount.

Chairman STARK. How much more time do you think that doctors could spend with patients if they didn't have to fill out those medical records?

Dr. EISENBERG. By and large what the physicians do is keep a progress note. They write the history and physical. The number of people who are involved with the chart is legion. I think last month's Life magazine had a picture of the number of people who are involved with caring for a patient with a coronary bypass graft at Georgetown—it is hard to say. Maybe 10 percent, 15 percent. I don't think much more than that.

Chairman STARK. What they want me to do is visit a hospital and then show how unnecessarily large the files are and I should talk to the doctor about how much time he or she could spend with their patients if they weren't responsible for filling out these medical records.

What I think they are doing, and I think it is disingenuous, is confusing whether it is with nurses or doctors, the records they keep which are largely on issues of the patient's health and medical procedures. I might quarrel with you about the need for it in malpractice, but I think those are distinctly different from the billing records for insurance companies and credit and that sort of thing. I think it is too bad that we are trying to sell the President's plan at such an ephemeral and pedestrian level.

It is serious business and I think not the kind of thing that we ought to sit around like we are selling Boys Scout cookies; but we ought to deal with it as you gentlemen have so ably done for us this morning.

We appreciate your hard work on a plan that is serious and one that ought not be treated so frivolously as has been suggested bring the PR machinery in the White House.

I thank the panel.

Our next panel includes representatives of senior citizens groups and I welcome Judith Brown as a member of the board of directors of AARP; and Martha McSteen, president of the National Committee to Preserve Social Security and Medicare.

When you are seated and comfortable, Ms. Brown may lead off and summarize or expand on her testimony followed by Ms. McSteen.

STATEMENT OF JUDITH BROWN, CHAIR, BOARD OF DIRECTORS, AMERICAN ASSOCIATION OF RETIRED PERSONS

Ms. BROWN. Good afternoon, Mr. Chairman.

As you know I am Judy Brown, chair of the board of AARP, and on behalf of AARP let me commend you again, sir, as well as other members of this Committee on both sides of the aisle for your attention to health care reform.

Let me begin by saying that the association is very pleased to have presidential leadership for comprehensive reform. He has included long-term care, prescription drugs and coverage for early retirees in his bill. These are critical components of reform for AARP members.

Let me now focus on a few key points from our statement. Health care reform is both a complex national issue and a highly personal issue and that is certainly true in dealing with the Medicare program. In Washington, Medicare is a \$150 billion system with hundreds of pages of law and regulation, but to millions of Medicare beneficiaries, it is my health care plan, and despite its shortcomings it is an enormously successful and popular program across all age groups.

If for some inside the Beltway Medicare is a ballast dragging down the budget, to real people beyond the Beltway, it is a lifesaver without which they would sink. I say all this to emphasize a critical point. Our health care system needs comprehensive reform and Medicare must be part of that reform, but let's not confuse bold action with precipitous action or throw out what works simply for change's sake.

The second and related point is the magnitude of Medicare savings in the administration's proposal. Controlling health care costs throughout the system must be a central goal of health care reform, and Medicare can be expected to be a part of that effort, but the magnitude of proposed savings, \$124 billion, is alarming on its face.

Over the past decade, Medicare has absorbed roughly \$200 billion in cuts, \$56 billion just earlier this year. Medicare now pays an average of only 65 cents on the dollar compared with private payers. Increasingly our members tell us that they are paying for these Medicare cuts in reduced access.

A critical question for the association and its members is whether the President's proposal or any other reform proposal will reduce Medicare private payment gaps and begin to address Medicare access problems. Absent systemwide cost containment, the association will oppose further efforts to cut Medicare.

AARP is also concerned that the President's plan would provide worse coverage for Medicare beneficiaries than for younger populations. For example, Medicare beneficiaries would not have an annual limit on total out of pocket spending, and low-income protections would remain inadequate.

In that light, the President's proposal to establish home health and lab coinsurance as well as the technical outpatient hospital savings measures would create significant hardships for many Medicare beneficiaries particularly those with low to modest incomes. We hope that these and other problems can be addressed as the proposal works its way through Congress. The need for health care does not decline when one celebrates his or her 65th birthday. It only increases for most.

AARP strongly supports retaining Medicare as a distinct program rather than dismantling it or forcing beneficiaries into state based alliances. If Congress decides to grant a limited number of States the authority to integrate Medicare into broader statewide systems, the association urges that States be required to dem-

onstrate with thorough Federal oversight—not simply assure—that Medicare beneficiaries will receive the same benefits as those under 65 and that Medicare funds are earmarked so that States cannot divert such funds for other purposes.

We are not convinced that States could handle a takeover of the Medicare program. It will take time to learn how to run a new system without adding 35 million additional people. Medicare-eligible individuals who do get coverage in alliances because they are younger and/or working are likely to be healthier than the rest of the pool. We are gravely concerned that this could lead to a withering of the actuarial base of Medicare.

In conclusion, the President's plan incorporates many of the features that AARP has supported in its own proposal, and we will work with Congress in a bipartisan way to ensure that comprehensive benefits are guaranteed to Americans of all ages in a final health care bill.

Thank you.

[The prepared statement follows:]

**STATEMENT OF JUDITH BROWN
AMERICAN ASSOCIATION OF RETIRED PERSONS**

Good morning. My name is Judith Brown. I am Chair of the Board of Directors of the American Association of Retired Persons (AARP). Thank you for the opportunity to testify today on Medicare savings in the President's plan for health care reform. Before focusing on Medicare savings, however, I would like to restate the Association's strong commitment to reform.

Our nation needs comprehensive health care reform. Americans need bold, not timid, steps - now.

Comprehensive health care reform means:

- o A guarantee that all individuals have access to and coverage for health and long-term care;
- o System-wide cost containment that slows the explosive growth in health spending;
- o Comprehensive benefits, from prenatal care and prevention to prescription drugs and long-term care;
- o Consumer-centered governance of the health care system; and
- o Broad-based, fair and affordable financing, so that government, businesses, and individuals all pay their share and everyone is protected against the high costs of care.

While AARP has not yet endorsed any specific health care reform plan, we believe the President's proposal provides the strongest and most realistic blueprint to date for achieving our goals.

We are particularly pleased that the President has included the following critical provisions in the Health Security Act:

- o a home and community-based long-term care benefit for disabled persons of all ages;
- o coverage of prescription drugs on similar terms for Medicare beneficiaries as for all other Americans; and,
- o protection for pre-65 retirees.

Recognizing the importance of bipartisan consensus in solving this very complex problem, we also commend the members of Congress in both parties who have introduced proposals that would achieve universal coverage.

AARP's "Health Care America"

AARP's proposal for comprehensive health care reform, "Health Care America," was developed with the extensive involvement of AARP members across the country. Its centerpiece is universal coverage through a strengthened and expanded Medicare program in which everyone would be eligible for a comprehensive, nationally mandated package of medical and long-term care benefits. Employers would be required to contribute to the cost of their workers' benefits, either through the expanded Medicare program or through private coverage. In addition to ensuring access, the system would foster choice, diversity, and innovation in the delivery of health services. Finally, the system would be accountable to consumers through a new Federal Health Care Commission that would set spending targets and establish other rules.

"Health Care America" reflects the Association's commitment to improving the quality of life for all generations -- a commitment we believe is shared by President and Mrs. Clinton, members of Congress, and the American people.

Financing Health Care Reform – Some Observations

AARP looks forward to an open discussion of the cost and financing estimates of health care legislation. This scrutiny is critical because if proposed savings and revenues do not materialize, then important benefits will be reduced and/or the entire reform effort may be jeopardized. Experience has shown that cost estimates only increase as the legislative process advances.

Experience with the enactment and repeal of the Medicare Catastrophic Coverage Act, in particular, provides this and several other lessons on financing health care reform:

- o The American people must view the benefits as comprehensive if they are to be willing to pay for them. Older Americans viewed the new Catastrophic benefits as too meager to warrant widespread support, particularly because long-term care was not included.
- o Financing cannot be narrowly imposed on a small segment of the population. Medicare beneficiaries were required to pay 100% of the cost of the Catastrophic program, increasing the flat and income-related premiums to extraordinary levels.
- o It is unrealistic to front-load the "pain" of financing without a corresponding "gain" in benefits. While most older Americans have shown great patience in their lives, asking them for a full downpayment well in advance of receiving Catastrophic benefits proved unacceptable.
- o Effective cost containment is critical to keeping benefits and financing affordable. Due to the lack of effective cost containment, the projected cost of the Catastrophic drug benefit (and the resulting estimates of premiums to be paid by beneficiaries) skyrocketed even before the bill made its way through the conference committee.

Medicare: Don't Weaken A Successful and Popular Program

Medicare is the cornerstone of health care coverage for older Americans. Since its inception, Medicare has dramatically increased access to health care for those age 65 and over and the disabled by guaranteeing that coverage is available regardless of health status and by attempting to keep costs for Medicare-covered services affordable. Today, about 35 million Medicare beneficiaries receive important benefits like physician services, hospital care, and home health care.

Medicare's low administrative costs -- about 2 percent of program outlays in 1992 -- help maintain its reputation as one of the more efficient federal programs. By contrast, administrative costs of private health insurance range from 5.5 percent to 40 percent of benefit costs.

Here, inside the beltway, Medicare is a \$150 billion "system" with hundreds of pages of law and regulations. But to the millions of Medicare beneficiaries, it is "my health care plan." And, despite its shortcomings -- such as gaps in benefits, lower payment rates, and confusing paperwork -- it is an enormously successful and popular program, across all age groups.

Our health care system needs comprehensive reform, and Medicare must be part of that reform. Medicare needs improved benefits and access for its beneficiaries. We shouldn't weaken what already works in pursuit of a better overall health system.

Medicare Savings in the President's "Health Security Act"

The President's plan proposes \$124 billion in Medicare cuts between 1996 and the year 2000. An additional \$28 billion of Medicare savings is estimated to result from the requirement that employers pay 80 percent of health care premiums for working Medicare beneficiaries. These reductions come on top of the \$56 billion in Medicare savings enacted just three months ago in the 1993 budget reconciliation act, the \$43 billion in Medicare savings enacted in OBRA90, and more than \$80 billion in cumulative Medicare savings throughout the 1980s. Increasingly, we are hearing from our members that they are paying for these Medicare cuts in reduced access to care.

Controlling health care costs throughout the system must be a central goal of health care reform. Reform must include enforceable limits on private sector health spending, such as premium limits or ratesetting, if it is to be credible. The Congressional Budget Office (CBO) recently found that while Medicare spending grew at an annual per-capita rate of 3.1 percent between 1985 and 1991, total U.S. health spending grew at an annual per-capita rate of 4.8 percent. The reason for this difference is that Medicare is controlled through the federal budget process but private health care spending is not.

Medicare savings will also result from a system-wide approach to cost containment. But the magnitude of the proposed Medicare savings -- \$124 billion -- is alarming on its face. Absent system-wide reforms -- and if reductions are unmatched in the private sector -- the Medicare program could not sustain such enormous reductions without creating quality and access problems for beneficiaries.

Absent system-wide cost containment, the Association will oppose any further efforts to cut Medicare. Moreover, the proposed Medicare savings, even if they can be achieved, are not a broad or permanent financing source for health care reform. Once the system is made more efficient, we will need to identify more lasting funding sources for the public cost of health care delivery.

Below is our preliminary assessment of the specific Medicare cuts in the President's plan.

Proposals That Reduce Growth in Medicare Provider Payments

There is a widening chasm between what Medicare reimburses and what the private sector pays for hospital and physician care. According to the Physician Payment Review Commission, Medicare now pays physicians on average less than 60 percent of commercial rates. And, according to a recent CBO study, Medicare hospital rates are only 67 percent of private rates. These gaps in payments have resulted in greater cost shifting onto the private sector and less willingness on the part of providers to treat Medicare patients.

The President proposes to further reduce Medicare payment updates for both hospital and physician services, even before the reductions in the Omnibus Budget Reconciliation Act of

1993 (OBRA93) go into effect. At the same time, payment rates for Medicaid patients and the uninsured will increase to private insurance levels. The critical question for the Association is whether the President's private sector cost containment proposals will reduce Medicare-private payment gaps and begin to address Medicare access problems. In the new system, Medicare beneficiaries could become the least profitable patients for providers to treat and experience the same access problems Medicaid patients currently must face.

At this stage, there is not enough information for us to determine what the effect on beneficiary access of the proposed changes will be.

Proposals That Increase Beneficiary Payments

Home Health Coinsurance

The President's proposal calls for a 10 percent coinsurance on home health services. This would create a significant financial hardship for many Medicare beneficiaries, particularly those with low to modest incomes.

For the average home health user, the 10 percent coinsurance would cost about \$425 in 1994 alone. For the average user age 85 and older, the coinsurance would cost about \$560 in 1994. These increases are on top of the hospital deductible, physician coinsurance, and Part B premium -- \$2,500 on average -- that beneficiaries needing home health care typically face. The proposal also puts physicians who treat the frailest and sickest Medicare beneficiaries in the difficult position of recommending care they know their patients cannot afford.

Lab Test Coinsurance

The new 20 percent coinsurance proposed for lab services will hit hardest on those who already are likely to have high out-of-pocket costs, particularly those without medigap coverage. Additionally, it would create new paperwork to exchange very small amounts of money on millions of claims. For example, coinsurance would be two dollars for a complete blood count. In 1992, Medicare received over 63 million claims from free-standing clinical labs, in addition to those from physician offices and hospitals.

The best way to reduce Medicare spending for lab services is by reducing unnecessary utilization. And the best way to reduce unnecessary utilization is by changing physician and lab behavior. The law virtually eliminating physician self-referral to clinical labs took effect in 1992. Since then, the rate of increase in Medicare payment for lab services has slowed. Additional steps to slow utilization increases might include eliminating payment for those panel tests that physicians do not specifically order.

Establishing a lab coinsurance is not expected to reduce utilization of lab services because beneficiaries play only a very minor role in deciding whether to order tests and which tests to order.

Outpatient Hospital Coinsurance

Beneficiary coinsurance for hospital outpatient surgery, radiology, and diagnostic services far exceeds the standard 20 percent for other Part B services. This occurs because Medicare's payment is based on a blend of hospital and ambulatory surgery center costs and charges while beneficiary coinsurance is based solely how much a hospital bills for the service. Since the amount a hospital charges is usually higher than what Medicare approves, beneficiaries end up paying considerably more than the 20 percent coinsurance they pay for other Part B services. The Prospective Payment Assessment Commission (ProPAC) estimates that beneficiaries are paying anywhere from 37 to 54 percent in coinsurance. As beneficiaries increasingly receive services in hospital outpatient departments in lieu of inpatient care, the problem is getting worse.

The Administration recognized the outpatient coinsurance inequity and proposed eliminating it in the September 7, 1993, draft of the health care reform proposal. The proposed fix,

however, is noticeably absent from the final plan. Instead, the President's "Health Security Act" exacerbates the problem through what has been described as a "technical" change in how the Medicare payment for outpatient services is calculated.

Under the proposal, Medicare would end up paying the Medicare-approved amount for a service minus what the beneficiary pays in coinsurance. For instance, if a hospital charged \$300 but Medicare approved only \$100, then the beneficiary would pay \$60 (20 percent of \$300) and Medicare would pay only \$40 (which is \$100 minus \$60). As Medicare pays hospitals less for outpatient services, it puts pressure on hospitals to increase the amount charged to private patients. This results in a cost shift to beneficiaries because beneficiary coinsurance is based on 20 percent of the same hospital charge paid by private patients. As charges go up, beneficiaries will pay more. This vicious cycle won't stop until beneficiaries pay 100 percent of the Medicare-approved amount and Medicare pays nothing.

Income-Related Premium

AARP has strongly opposed increasing the Medicare Part B premium for higher-income beneficiaries outside the context of health care reform. In the absence of comprehensive reform, a high-income premium would constitute nothing more than a cost-shift to beneficiaries without adequate control over system-wide spending.

We also believe that if Part B premiums are income-related, then private-sector premiums should be income-related as well. In 1993 alone, the federal government will "spend" \$48 billion by providing tax breaks for employer-paid health care premiums. This provision is one of the fastest growing tax expenditures in the budget, and is projected to reach \$96 billion by the year 2000.

It does not seem fair that taxpayers would continue to subsidize the health care premiums of a Wall Street executive with a salary of more than one million dollars a year while subsidies to Medicare beneficiaries with much lower incomes are substantially reduced. If Congress and the President believe that "income relating" premiums is a good idea for the elderly and disabled, then it is at least as good an idea for the rest of the country -- including the Congress itself.

Continued Gaps in Medicare Coverage

We are very pleased that the Health Security Act would eliminate balance billing throughout the entire health care system, including Medicare. Since enactment of physician payment reform, the Medicare program has made great progress in this area; but under a reformed system it will be important to eliminate excess billing for all consumers and enforce this new policy aggressively.

Despite this improvement, however, it is important to keep in mind that while the President's proposal increases Medicare beneficiaries' premiums and cost-sharing, it maintains a high hospital deductible, fails to set limits on total beneficiary out-of-pocket costs, and does not expand currently inadequate low-income protections. As a result, Medicare coverage will be worse than coverage for the under-65 population. We hope that these gaps can be filled as the proposal works its way through Congress. The need for health care, as well as the need for assistance to pay for that care, does not decline when one celebrates his or her 65th birthday.

Additionally, Medicare beneficiaries would pay more for their coverage than individuals under 65. At today's rates, an individual in an alliance would pay about 20 percent of an average \$2,000 premium, or \$400 per year, while Medicare beneficiaries would pay \$583 per year in Part B premiums. Further, to make their benefits comparable with fee-for-service alliance benefits, Medicare beneficiaries would have to pay about \$840 additional per year for a Medigap policy, for a total of \$1,423 per year just in premiums.

About 10 percent of Medicare beneficiaries are too poor to afford medigap coverage but are not poor enough to qualify for Medicaid or the Qualified Medicare Beneficiary (QMB) program. The QMB program pays Medicare premiums and all Medicare cost-sharing for persons below the poverty level but pays only for Part B premiums for those between 100 and 120 percent of the poverty level (fully implemented in 1995). AARP strongly recommends that health care reform legislation expand QMB protections for low-income Medicare beneficiaries up to 150 percent of the poverty level -- to provide protection equivalent to what is provided for other age groups -- and make it easier for eligible beneficiaries to apply for QMB protections.

Medicare and Health Alliances

AARP strongly supports the President's intention to retain Medicare as a distinct program rather than dismantle it or force beneficiaries into state-based alliances. There are four fundamental reasons for preserving Medicare as a separate program under the President's plan.

First, as currently proposed, health alliances are not required to provide equal coverage for Medicare beneficiaries. Those who have suggested forcing Medicare beneficiaries into alliances at the outset ignore the fact that older Americans would likely get worse coverage and pay more in premiums than others in the alliance. Until the alliance system can provide equal coverage for older Americans at similar rates, they should not be "incented" into the alliance system. The first step toward integration of Medicare should be to expand Medicare benefits and out-of-pocket protections. At a minimum, the over-65 alliance enrollee should enjoy the same benefit package, cost-sharing, annual out-of-pocket limits, and low-income protections that the under-65 alliance member has.

Second, Medicare can be thought of as its own national health alliance. Under the President's proposal, each health alliance would constitute a separate "risk pool" within which premiums would be community-rated. Medicare has operated in this manner for the past twenty-eight years.

Alliances would allow individuals and their families to choose between fee-for-service and managed care plans. Medicare already allows beneficiaries to choose HMOs or PPOs in areas where they are available. However, there are many areas of the country where such plans are not offered, and, therefore, only 7 percent of Medicare beneficiaries are enrolled in managed care plans. The President proposes expanding Medicare managed care choices and incentives for beneficiary enrollment.

Alliances would also be charged with limiting health care premiums and payments to providers -- an area in which Medicare has already demonstrated some success.

Third, older Americans are very reluctant to "give up" the Medicare program with which they are very familiar for a new and untested approach. Seniors rely greatly on Medicare for their health care needs, despite the gaps in Medicare coverage. The system functions well for 36 million beneficiaries, but we know little of how the alliances would work.

According to a recent survey conducted by AARP, 43 percent of respondents age 50 and older oppose the idea of states folding Medicare into their health plans. However, 64 percent of those who do not strongly favor this idea would favor it if they could get substantially better benefits under the state plan.

Fourth, we are not convinced that states would be able to develop and maintain consistent, high standards with respect to the oversight and enforcement that would be necessary to support a takeover of the Medicare program. It will take time and experience for the states and alliances to learn how to run a new system without adding 35 million more people. If Congress decides to grant a limited number of states the authority to integrate Medicare into broader statewide systems, the Association urges that the public be given ample opportunity

to review and comment on such waiver requests and that states be required to demonstrate -- with thorough Federal validation -- not simply "assure," that:

- Medicare beneficiaries will receive the same benefits and protections as the under-65 population; and
- Medicare funds are earmarked so that states cannot divert such funds for other purposes.

Conclusion

In conclusion, Mr. Chairman, AARP believes our health care system needs comprehensive reform and that Medicare needs to be part of that reform. But in pursuit of a better health care system, we should not weaken Medicare or leave Medicare beneficiaries without adequate health care protections.

We commend the President, as well as the many members of Congress on both sides of the aisle who have brought the issue of health care reform to this stage. The President's plan incorporates many of the features that AARP has supported in its own proposal.

AARP will work with the Congress in a bipartisan way to ensure that comprehensive benefits are guaranteed to Americans of all ages in a final health care plan. Strengthening Medicare is a critical step toward that guarantee.

Chairman STARK. Ms. McSteen.

STATEMENT OF MARTHA McSTEEN, PRESIDENT, NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

Ms. McSTEEN. Thank you, Mr. Chairman. We know that this subcommittee and particularly you will work hard so that whatever changes are made will be good for all Americans, including Medicare beneficiaries.

My comments will focus on four areas: the context of Medicare cost containment, the link between Medicare savings and new benefits, increases in Medicare beneficiary out-of-pocket costs, and the impact of Medicare cutbacks on providers.

Cost containment must start with the private sector which is behind the public sector in its efforts. Medicare per enrollee real spending growth has been 2.9 percent compared to 4.3 percent real health care per capita spending growth for the Nation as a whole between 1985 and 1990.

Some enforceable mechanism for controlling private sector costs such as the cap on premiums are a minimum prerequisite for the National Committee to accept Medicare cuts. Managed competition market reforms alone are unlikely to achieve immediate cost savings of the magnitude required to justify the proposed level of Medicare cuts.

The national committee believes there is no reason that the long-term care benefits for all Americans should be conditional on Medicare savings.

Chairman STARK. Let me stop there a minute. I presume then because the Chafee plan that is just being introduced would predicate everybody's health care participation based on savings; in other words, not only would it be Medicare long-term care, but the Chafee plan would say young people or uninsured people or part-time workers would not get their insurance until and unless we had government savings. I presume you would object to that as well?

Ms. McSTEEN. Right.

Even if it is possible to realize all the proposed savings, we think that we must watch very carefully and hope that the Congress is committed to these benefits even if the full savings do not materialize. Certainly there should be a mechanism to earmark savings to guarantee that they will first be used for the Medicare prescription drug and long-term care benefits. This could be done by making it a part of the budget enforcement mechanism.

Let me mention higher premiums for upper income. Despite the recommendation of many managed competition advocates, the administration has chosen to leave untouched the tax break given to employer health insurance contributions and even expand it to the self-employed even though Medicare beneficiaries with higher incomes would have their premiums tripled.

There is hospital outpatient copays that the national committee is concerned about and we were disappointed that the administration took out of the plan a long overdue reform of the beneficiary copay formula for outpatient hospital services. Currently as you know, beneficiaries pay 20 percent of the hospital computed charges rather than 20 percent of what Medicare allows. This re-

sulted in \$1 billion in excessive beneficiary copays in 1991, according to the National Committee study.

Copay reform would have moderated some of the other changes and it would have been easy to implement along with the new hospital outpatient prospective payment system.

As to balanced billing, the National Committee strongly supports the elimination of balanced billing, which costs Medicare beneficiaries about \$1.7 billion, according to an AMA study.

We are greatly concerned about the administration's payment reform mechanisms and how they would affect Medicare payments and access to care for Medicare beneficiaries. The National Committee believes that any significant differential in payments between Medicare and alliance health plan payments could make Medicare beneficiaries second-class citizens.

The administration's proposal to limit premium increases and reduce Medicare spending will lead to an unprecedented slowing in the growth of provider revenue that may or may not leave in place the current differential that exists between Medicare and the private payers. We need to be careful in monitoring the effects of these reductions to insure that they are applied in a way that will not adversely affect access to the quality of services furnished to Medicare beneficiaries as well as to all Americans.

Mr. Chairman, we appreciate the administration bringing health care reform to the forefront. We also applaud your efforts to further a plan that is fair to all Americans.

Thank you.

[The prepared statement follows:]

TESTIMONY OF MARTHA McSTEEN

NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

I am Martha McSteen, President of the National Committee to Preserve Social Security and Medicare. The National Committee's six million members and supporters will be affected by any changes in the health care system, especially changes in Medicare. We know that this Subcommittee and you in particular, Mr. Chairman, will work hard so that whatever changes are made will be good for all Americans, including Medicare beneficiaries.

Our comments will focus on four areas, (1) the context for Medicare cost containment, (2) the link between Medicare savings and new benefits (3) increases in Medicare beneficiary out-of-pocket costs, and (4) the impact of Medicare cutbacks on providers.

Context for Medicare Cost Containment

Most would agree there is a lot of waste in the health care system. Casual observation leads to that conclusion as well as economic analysis. The United States spends 14 percent of its income on health care, much more than any of our economic competitors. On the face of it, it should be easy to decrease total health care spending to 17 percent of GDP. But it may not be that easy to step on the brakes given consumer expectations and the financial consequences for those whose livelihood is linked to the health care industry.

Cost containment must start with the private sector which is behind the public sector in its efforts. Medicare per enrollee real spending growth has been only 2.9 percent compared to 4.3 percent real health care per capita spending growth for the nation as a whole between 1985 and 1990.¹

Some enforceable mechanism for controlling private sector costs, such as the cap on premiums, are a minimum prerequisite for the National Committee to accept Medicare cuts. Managed competition market reforms alone are unlikely to achieve immediate cost savings of the magnitude required to justify the proposed level of Medicare cuts. Whatever the mechanism, however, we are uneasy with any plan to legislatively determine the level of cuts in either the private sector or Medicare five to seven years in advance. This precludes any adjustments or flexibility that may be necessary. Effective cost containment also should not preclude annual negotiations with providers and consumers about the proper level of spending.

The proposed Medicare cuts are more than double the \$56 billion in cuts over five years as part of this year's budget bill. Cumulative cuts include \$43 billion over five years in 1990 and additional cuts in 1985, 1987 and 1989. The overall impact is staggering.

Link Between Medicare Savings and New Benefits

The National Committee believes there is no reason that the long-term care benefits for all Americans should be conditional on Medicare savings. Even if it is possible to realize all the proposed savings—and that is a questionable assumption—these savings could also have been used to make Medicare benefits as good as the standard benefit package. We hope that Congress is committed to these benefits, even if the full savings do not materialize. Relying on other funding sources for some of the cost would be more fair.

We are also concerned that Medicare savings might be siphoned off for other high priority health care programs, if these new benefits prove to be more costly than anticipated. We believe a mechanism is needed to earmark savings to guarantee that they will first be used for the Medicare prescription drug and long-term care benefits. This could be done by making it a part of the budget enforcement mechanism.

Increases in Medicare Beneficiary Out-of-Pocket Costs

It is frequently overlooked that some of the proposed cuts are really increases in out-of-pocket costs for Medicare beneficiaries that could be described as persistently biased against seniors. This is not real cost containment, just cost shifting. Based on the Administration's estimates almost 20 percent of proposed

¹Congressional Budget Office.

savings, or \$24 billion directly affect beneficiaries. By comparison, the 1990 and 1993 budget bills increased out-of-pocket costs for beneficiaries by \$10 billion and \$7 billion.

Home health and lab co-pays. The Administration proposes a 20 percent co-pay for laboratory services and a 10 percent co-pay for home health services more than 30 days after a hospital stay. The argument for this is that it puts these co-pays more in line with co-pays for other Medicare services and co-pays for similar services under the standard benefit plan. On the other hand, the standard benefit plan is more generous overall than the Medicare benefit plan, and caps out-of-pocket expenses at \$1,500 annually.

Part B premium increase in 1999 and 2000. Under current law, premiums cover about 25 percent of program costs. This "temporary" provision has been in effect since 1982 and the Administration proposal would continue it permanently after the temporary provision expires in 1998. By itself, it doesn't seem unreasonable unless the Medicare Part B premium is compared to the average premium for the standard benefit for non-Medicare individuals. The Administration estimates that the non-Medicare individual would pay a premium of \$32 a month in 1994 for the average standard benefit plan. In contrast, Medicare beneficiaries will pay \$41.10 a month in 1994 and an additional \$11 for the new Medicare prescription drug benefit for a total of \$52—or \$20 more than non-Medicare individuals. The higher premiums to be paid by Medicare individuals compared to non-Medicare individuals is a major flaw in the Administration's health care reform proposal.

Higher Premiums for Upper Income. This was first proposed by the Bush Administration. Beneficiaries with adjusted gross income over \$100,000 (\$125,000 for couples) would pay three times the current Medicare premium. The higher premium would be phased in for those with adjusted gross income over \$90,000 (\$115,000 for couples). The higher premium would cover approximately 75 percent of program costs. Proponents argue it would "recapture" the Medicare Part B subsidy from 700,000 Medicare beneficiaries. Someone might accept that argument on its face unless he or she realized that the Administration was not proposing to limit tax subsidies to equally well-off non-Medicare beneficiaries. Despite the recommendation of many managed competition advocates, the Administration has chosen to leave untouched the tax break given to employer health insurance contributions and even expand it to the self-employed.

Hospital Outpatient Co-Pays. The National Committee is disappointed that the Administration took out of the plan a long overdue reform of the beneficiary co-pay formula for outpatient hospital services. Currently, beneficiaries pay 20 percent of the hospital-computed charges rather than 20 percent of what Medicare allows. This resulted in \$1 billion in excessive beneficiary co-pays in 1991, according to a 1992 National Committee study. Co-pay reform would have moderated some of the other changes and it would have been easy to implement along with a new hospital outpatient prospective payment system.

Balance Billing. One positive change for Medicare beneficiaries is a prohibition on balance billing which will greatly enhance beneficiary protection. The National Committee strongly supports the elimination of balance billing which costs Medicare beneficiaries \$1.7 billion, according to a study by the American Medical Association.

Impact of Medicare Provider Cuts

We are greatly concerned about the implications of the Administration's payment reform mechanisms and how they would affect Medicare payments and access to care for Medicare beneficiaries. The National Committee believes that any significant differential in payments between Medicare and alliance health plan payments could make Medicare beneficiaries second-class citizens and lead to rationing of care for our nation's seniors. For example, in 1991 Medicare payments to hospitals represented about 88 percent of the cost of treating Medicare patients. Hospitals were able to accept Medicare paying less than their costs because they turned around and charged private payers more, which is commonly referred to as "cost shifting."

To date, Medicare's reductions in the rate of hospital spending growth have had little effect on hospital performance, according to Stuart Altman, chairman of ProPAC, because hospitals were able to cost-shift. Under the President's plan,

hospitals will not be able to generate extra revenue from the private sector because of tight premium controls. What will happen to Medicare beneficiaries when private payers no longer subsidize hospital care for Medicare beneficiaries? We are entering uncharted waters. We do not believe that we can rely on the lack of adverse effects from past Medicare payment practices to be indicative of what will happen in the future.

The same concerns can be raised about payments to physicians. If Medicare and alliance payments to physicians are structured in a way that makes physicians believe they are under paid relative to alliance health plan payments, will they refuse to take Medicare patients? Our members in some parts of the country already have had trouble finding physicians willing to treat them. We cannot afford a new system that will accelerate or exacerbate this problem.

The Administration's proposal to limit premium increases and reduce Medicare spending will lead to an unprecedented slowing in the growth of provider revenue, that may or may not leave in place the current differential that exists between Medicare and private payers. We need to carefully monitor the effects of these reductions to ensure they are applied in a way that will not adversely affect access and the quality of services furnished to Medicare beneficiaries, as well as to all Americans.

Conclusion

Mr. Chairman, we appreciate the Administration bringing health care reform to the forefront. We also applaud your efforts to further a plan that is fair to all Americans.

Chairman STARK. I want to thank you both. I want to ask again both of you if you have any fairly recent polling data, I guess would be what I would ask, among your membership or among seniors at large.

I am not looking for puffery and how they may or may not love Medicare, but that would indicate to us problems that your members see day-to-day with Medicare—because I do have some concern that while we are sitting here—and the Chair wants to constantly remind folks what a wonder full system it is—if we get too sidetracked on the reform business we may overlook some of the problems like balanced billing and outpatient services, which is atrocious, and some of the increased charges on home health care which is equally atrocious and should be brought under control.

So if you either keep track of complaints that you receive or polling data, the Chair would very much appreciate your constructive or just nasty criticism of the Medicare system and what we are currently doing.

Ms. BROWN. I believe that we are in the process of gathering some of those things now and would be very glad to share that with you when we receive it.

[The American Association of Retired Persons is still in the process of collating the data and will supply the results to the subcommittee when available.]

Chairman STARK. You are both in agreement as is the Chair that if we are required to make these cuts in Medicare, and we can do it; it is easy. I can't tell you what the results will be but making the cuts is a slam dunk.

I am not so concerned about making the cuts if in fact you have an identical cost containment system on the private side. Then we are all in the same box, and if the doctors aren't going to practice they aren't going to practice or my kids or me or my mother, then we will all suffer equally. I hope we don't have to do that.

My question is particularly, starting with you Ms. Brown, you mentioned that there has to be systemwide cost containment. Doesn't that imply to you that we can't have two very different cost control systems, one for private and one for public, Medicare, Medicaid or we will open the door to gaming and a variety of patient selection games that would allow subtle discrimination against the lower paying providers, which arguably would be on the government side?

There is some similarity in the President's plan in that both his plan and Medicare do set premiums, Medicare only for risk contractors, but we set a premium. How you set it there is a world of difference between them and the same is true of fee-for-service, DRG's, the President's plan and current HCFA practices set fees for hospital reimbursement.

If you left that open to alliances or local groups you could soon find a lot of differences between how you pay hospitals and end up with the same problem. You could call it cost containment, but if it isn't quite universal, do you share my concern that we would end up with the problem that you anticipate with no cost containment?

Ms. BROWN. Yes, we are very concerned. Obviously \$124 billion is a lot of money. Not only is it a lot of money, but there are a lot of people at the bottom who are using that program who are going

to be hurt. If we don't have cost containment across the board, we cannot support any of that.

It will be difficult enough for Medicare to take another hit, and without premium caps or some mechanism by which we can even the playing field and stop Medicare payments being less and less of what everyone else is getting, what we are going to do as you indicate so well is we are going to have two systems and that is not what we are supposed to be doing here.

Chairman STARK. The other result of that is to drive everybody out of the Medicare system into the open arms of the alliances, that is a risk I am willing to take at such point that we can. I think you both alluded to that, that we can have some confidence that the alliances have both the responsibility and the resources and the ability to provide at least as good and secure coverage as Medicare does now.

Absent that, I think we would be foolishly risking the medical delivery system for seniors, and while they are—I would not underestimate their ability to bring political pressure to bear; nonetheless I don't want to underestimate the ingenuity of the hospital and the medical delivery system for finding new ways to enrich themselves and/or to take risk selection, which could basically close the doors to Medicaid beneficiaries and if Medicare beneficiaries ended up in the same place to them——

Ms. BROWN. We run the risk as we permit people who turn 65 to remain in the alliances and not discussing whether they would get the same or may pay a little more, we leave within Medicare those people who are older and more frail who need more care and are more expensive, and that population is growing.

Chairman STARK. I have often said the President's plan is a blueprint. Dr. Vladeck's testimony to the contrary notwithstanding I have heard stated by members of the White House staff that they would love, as a matter of fact, it was their intention and would have tried to disband Medicare right from the get-go.

No question that this proposal is designed to unwind the Medicare and turn it over to alliances. I don't think it takes a Ph.D. in medical economics to figure that one out. It makes political good sense to deny that that is the intention, but the details of the plan make it pretty hard to accept that that isn't what the plan will do.

I would say 5 years and you would see the system would have real financial problems or it would be just left with this most severely elderly and acute patients. Either one is a scenario to destroy the system.

Let me quickly get on to two other issues, the income-related premium.

The Chair has never objected to making any of our plans somewhat more progressive, but still has some battle scars from the last time that was attempted, and it was as a matter of fact exacerbated I think by the attempt to not call a tax a tax, and hop through a bunch of hoops in an effort to appease some Senators who have now risen to higher levels, who said we couldn't call it that, and the unions I might add, who felt that because their contracts called for premiums to be paid by employers, if we called it a tax, the employers would get stuck with the additional cost. I thought we could have corrected that legislatively.

I want you to both comment on whether you think there is some room because there is a clarion call to charge upper income beneficiaries, something to extract a little bit more from upper income beneficiaries. I would like your general thoughts on that, and then the question of what you think the idea of making the alliances—whether you think those are necessary. Do you want to try either one of those? Strike that one.

Long-term care—now, I am still a little confused, but to me in relation to both of your organizations with whom I have dealt for a long time on the issue of providing long-term care to seniors, recognizing that it is not necessarily a problem that is limited to seniors, but I would suspect that certain parts of it are of greater concern to seniors largely because many seniors end up being single women at the time that long-term care is needed without a family remaining behind, and I think some of the implications to the need for long-term care impact on seniors more significantly.

Having said that, once you finish commenting briefly on the income relating, can you give me an idea what you think of this block grant to States which would not necessarily require the Governors to spend any specific amount on long-term care, but let them pretty much spend it as they chose in a kind of wide smorgasbord of expenditures they could spread around.

Ms. MCSTEEN. The upper-income issue is one that we are very concerned about. Once you begin to really means test, if you will, a social program, then it is only going to extend to all other social programs, and that is a drastic change in the way this country has done business.

Chairman STARK. So you are concerned as much about what it might do to Social Security for instance—

Ms. MCSTEEN. As well as health care, and then I think, although this is minor in many respects, people do not realize perhaps that trying to determine what that upper income is individual by individual can be an administrative nightmare.

I am aware of that from my long experience in Social Security when it is necessary to determine what income is for SSI. I think we have a big problem there that is not being weighed in, the cost of administration.

To address the block grant to States, we are very concerned about that wide-open option that it will be limited in some States. We hear from all across the country that adult day care is an essential element of coverage not just for the disabled, but also for the care givers. We need to be looking at that in terms of delivering the health care. Long-term care itself as is now mentioned in the administration's bill does still imply nursing home care.

I think we must watch that communication gap and make certain that people at the local level certainly understand what we are talking about; that it is a minimum coverage in my opinion when you talk about day care and adult day care and community care. We are just not going as far with that as our members feel that we should.

Chairman STARK. Thank you. Ms. Brown.

Ms. BROWN. On the issue of income-related costs, we are not thrilled with the thought of doing that. If it were to occur across-the-board for everyone in America, we would go along with it, but

for older people only, we would once again—we have been that route before.

Chairman STARK. Would you not prefer doing it at the front end and making a more progressive tax that we pay for? It is made somewhat more progressive for Medicare. For instance, when you take the cap off, people who earn a lot pay a lot more during their working lifetime for the same benefit basically, so that has some progressivity to it, and I tend to favor the idea of letting people in their higher earning periods pay more if they earn more as we do for a lot of other things in this country, and then let the benefit go as a social benefit rather than an income-related benefit.

Ms. BROWN. I think we would be willing to look at that as an alternative. I think it is very important, one of the things that we learned in catastrophic is that—and painfully—is that our members are very uncomfortable when they are singled out for something like that, and we need to address that issue, I think.

On the issue of long-term care, everything that we do indicates, and we are absolutely committed to the fact that there must be long-term care in any health care reform, every bit of research that we do indicates for people of all ages in America that without long-term care, health care reform support just goes out the window, so we must have that.

We are very concerned with the block grant type of home health care. We are not sure that it has enough support in there, that the States have so much leeway that they, when they look at the risk that they are undergoing, there is no demand that they even provide the service.

I was talking with another board member not too long ago, and in Florida alone they have 20,000 requests in one office for home health care, and they have just stopped keeping the figures, so what we do here is we say, well, we will tell you whether or not you need the care but we are not necessarily going to give it to you.

We all know the issue for older Americans is that they want to stay in their home, they want to have home health care, they want to be able to take care of themselves, and this is an essential ingredient for any health care reform act.

Chairman STARK. Just finally, both of you, if you had to choose in the supervision and the design and the oversight of these, of the proposed reforms, both for long-term care and acute care, would you rather have it done by the 50 States or the Federal Government?

Ms. BROWN. In our health care reform act, Health Care America that AARP developed, we did have the States doing the oversight for long-term care, but there needs to be enough constraints and regulations involved that we will be able to determine whether or not the States are doing what they are asked to do.

Chairman STARK. Based on the States' record on Medicaid as opposed to the Federal record on Medicare, you are comfortable that you would turn the Medicare administration over to those same States?

Ms. BROWN. Medicare we do not want to turn over.

Chairman STARK. Just for those other folks?

Ms. BROWN. We think that those States—

Chairman STARK. You want to stick me with Governor Wilson, but you don't want him, is that what you are telling me?

Ms. BROWN. We think the States are going to have enough of a task taking care of the alliances in the beginning, and if we can then show that there is ability to take care of all of it, we will see how it goes. We are going to be revisiting, we think, many of these issues, sir.

Chairman STARK. Ms. McSteen.

Ms. MCSTEEN. Yes, the demonstration projects seem to offer some alternatives. I don't think there is enough money there to do much in the States in the demonstrations. But I think that, if the States in fact are going to be responsible, that it would be well to have those demonstrations expanded. At the local level there are innovations, and knowledge of the economic conditions of the community make a great deal of difference.

I would like to say just one thing about physician assignment. No matter what else happens, I hope that you can maintain that physician assignment remains a part of any legislation. It is the paperwork, as you know and you referred to earlier today, that is such a burden on everyone. Certainly we have to have the paperwork, but seniors would be greatly relieved in order to have some of that paperwork removed.

Chairman STARK. I think so would a lot of people. I want to thank both of you very much for your continued contribution to this as we try and make some sense out of the various plans and see what we can get passed to help the American people. Thank you very much.

Chairman STARK. Our next panel includes three witnesses representing medical groups. I would like to welcome Dr. William Jacott, who is a member of the board of trustees of the AMA; Thomas Lewis, who is senior vice-president and chief executive officer of the American Hospital Association; and Dr. Tracy Walton, who is president-elect of the National Medical Association.

Welcome, ladies and gentlemen, to the subcommittee, and I will ask you to proceed to summarize or expand on your testimony in the order in which you were introduced.

Dr. Jacott.

STATEMENT OF WILLIAM E. JACOTT, M.D., MEMBER, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION, ACCOMPANIED BY JANET HORAN, DIVISION OF FEDERAL LEGISLATION

Dr. JACOTT. Thank you very much, Mr. Chairman.

As you know, I am Dr. William Jacott. I am a family physician at the University of Minnesota, and a member of the AMA Board of Trustees. With me is Janet Horan, who is from our division of Federal legislation.

As a starting point, the AMA never expected that we would agree or disagree with all the elements of any proposal for health system reform. Clearly, we agree with universal access, increased accountability, insurance reform, patient choice, and certainly a decrease in the administrative burdens and costs. We also agree that the status quo is unacceptable, but today we are focusing on an area where we disagree. I am pleased that the committee is devoting

careful attention to the President's Medicare proposals, proposals that include massive spending cuts and an overhaul of the RBRVS.

We are very concerned that these proposals will undermine the fundamentals of physician payment reform and threaten access for Medicare beneficiaries. They send the wrong signals about the degree to which physicians and other Americans can expect government to honor commitments made as part of health system reform.

We share the concerns expressed in the recent bipartisan letter to the President from Members of this House of Representatives, and it stated that the administration's proposals, coupled with OBRA 90 and 93, "will continue to push many health care providers toward the brink of financial disaster and risk eroding access to care for millions of poor, elderly, and disabled Americans."

The Medicare part B cuts proposed in the plan violate the fundamental elements of Medicare physician payment reform. They inject instability and certainly complexity into a system that was developed to provide just the opposite. They promise to dramatically accelerate the downward spiral of Medicare physician payments and they increase cost shifting pressures.

We have profound concerns about the broad implications of these cuts. For example, let's look at the establishment of a cumulative Medicare volume performance standard to replace the current MVPS. The penalty for exceeding the MVPS and, for that matter, for errors in projection would compound each year, and the concept of physician responsibility for volume and intensity of services becomes irrelevant in the confusion.

Also the possible rollback in 1995 of the 1994 conversion factor by 3 percent for all services, except for primary care, violates the agreement made when Congress created the MVPS. This would lead to a future diminishing of the real payments for services provided to Medicare beneficiaries.

The establishment of an elaborate "high cost" hospital staff MVPS is of great concern. This proposal would shift both hospital and physician payment incentives to penalize the physicians for advocating care for their patients.

Finally, competitive bidding is not an appropriate means to pay for professional health care services that are tailored to changing and highly individual needs. Patients and physicians who may be dissatisfied or concerned about quality with a provider should not lose the option of changing to a different provider for the services, and certainly there are other reasons besides cost for choosing who or what entity will provide a service.

In conclusion, we want the committee to know that physicians are eager to participate in a reformed American health system. However, change should be accomplished in a manner that builds on what works in our system, not on what destroys it.

Thank you, Mr. Chairman, for this opportunity.

Chairman STARK. Thank you very much, Dr. Jacott.

[The prepared statement follows:]

STATEMENT
of the
AMERICAN MEDICAL ASSOCIATION

to the

Subcommittee on Health

Committee on Ways and Means

U.S. House of Representatives

Re: Medicare Proposals From "The Health Security Act"

Presented by

William E. Jacott, MD

November 23, 1993

Mr. Chairman and Members of the Subcommittee:

My name is William E. Jacott, MD. I am a practicing family physician at the University of Minnesota and a Member of the Board of Trustees of the American Medical Association. With me today is Janet Horan, JD, from the Association's Division of Federal Legislation. The AMA appreciates this opportunity to appear today to discuss the subject of Medicare proposals from President Clinton's "Health Security Act."

The American Medical Association wholeheartedly supports the directions and goals of the Clinton Administration in its efforts to move the nation to a point where health care concerns will focus on maintaining health, and where apprehension over obtaining needed health and medical care services will become a problem from the past. We agree with all six of the yardsticks set out by President Clinton as the basis for measuring proposals for health care reform: security, simplicity, savings, responsibility, quality and choice. We are proud of the fact that these principles were the very same starting points used by the AMA in the development of our health system reform proposal, *Health Access America*. This is why we were eager to work with the new Administration in its efforts to develop a blueprint that would provide guidance for this Congress in enacting health system reform legislation.

The AMA never expected that we would agree or disagree with all elements of any proposal for health system reform. We are pleased that the public process of Congressional hearings and deliberations will allow the multiple elements that will constitute health system reform to be subjected to scrutiny based on the President's six points. We are pleased that the Committee is devoting careful attention to the Medicare proposals, set out in the President's Health Security Act, which include massive spending cuts and an "overhaul" of the Resource-Based Relative Value Scale (RBRVS). We are very concerned that these proposals fail the measuring criteria. They undermine the fundamentals of physician payment reform, threaten access for Medicare beneficiaries, and send exactly the wrong signals about the degree to which physicians and other Americans can expect their government to honor commitments made as part of health system reform.

Mr. Chairman, in testifying today and as we have testified in the past on budget proposals, we want to make it clear that many of these Medicare proposals would be opposed regardless of their context. Also, we do not believe that general health system reform should be financed through Medicare program reductions.

In addition to multiple problems with many of the individual Medicare proposals, we share the concerns expressed in the November 4, 1993 bipartisan letter to the President from forty-one (41) Members of this House of Representatives:

"Medicare and Medicaid savings of the magnitude that are contemplated in your proposal, coupled with those already enacted as part of the OBRA 93 and OBRA 90, will continue to push many health care providers toward the brink of financial disaster and risk eroding access

to care for millions of poor, elderly and disabled Americans. It is unclear whether the rigid, formula-driven budget caps that your proposal would impose on the Medicare and Medicaid programs bear any relation to the actual health needs of a community, or if they will be flexible enough to respond to changing and unforeseen circumstances."

If these Medicare cuts and modifications were to be enacted, that legislation would fail virtually every one of the yardsticks held up by President Clinton. And even though a substantial amount of savings would be attained, we are concerned that this would be achieved at far too great a human cost. As further stated in the Representatives' November 4 letter:

"... the level of reductions you have suggested in your proposal may place these important programs for the poor, elderly and disabled in severe financial jeopardy."

With these thoughts in mind, we offer the following specific comments concerning the Administration's proposed Medicare Part B changes.

MEDICARE PART B PHYSICIAN SPENDING CUTS

The Medicare Part B cuts proposed in the Plan violate fundamental elements of Medicare physician payment reform. In fact, the only one of the President's six principles that these proposals do not violate is "savings." They inject instability and complexity into a system that was instituted to provide just the opposite. They reflect a seeming and unseemly cynicism about physicians as "deep pockets" from which either reduction in the deficit or health system reform can be funded. They promise to dramatically accelerate the downward spiral of Medicare physician payments, increasing cost shifting pressures. Thus, physicians and patients must have profound concerns about the broad implications of these cuts. If these changes were enacted, this abrogation of the OBRA 89 agreements would raise questions for physicians about whether the very fundamental agreements reached to pass health system reform will be honored.

Establishment of Cumulative Expenditure Goals for Physician Services

Using fiscal year 1994 as a base, this provision would compare the two factors of cumulative Medicare Volume Performance Standards (MVPSs) and cumulative actual expenditure increases to determine the annual default conversion factor update. The conversion factor update for a category of physicians' services for a year beginning with 1996 would increase or decrease by the percentage by which the cumulative increase in actual expenditures for that category of physicians' services for that year was less than or greater than the MVPS for that category of services for that year.

Preliminary simulations of this proposal demonstrate that the cumulative MVPS will almost certainly send Medicare physician payments into a tailspin from which they will never recover. This new "update" process would be compounded by the increases in the performance standard factor (the OBRA 93 arbitrary 4% reduction from projected spending), the proposal to substitute real Gross Domestic Product (GDP) for the real data on historical medical volume and intensity, and the proposed elimination of any floor on payment reductions. With expenditures highly likely to come in over the target in future years, fees probably would be reduced each year and there would be no limit on this reduction. The penalty for exceeding the MVPS compounds each year, and the concept of individual physician responsibility for the volume and intensity of services become irrelevant in the confusion.

Use of Real GDP to Adjust for Volume and Intensity

The Clinton proposal would replace the medical volume and intensity factor from the MVPS and replace it with the average per capita growth in the real GDP for the 5-fiscal-year period ending with the previous fiscal year (increased by 1.5 percentage points for primary care services). While we do appreciate the improvement this represents over the September 7 draft, that proposed elimination of this factor entirely, this will only serve to further drive down updates. In general, growth in real GDP per capita has been far below historical levels of medical volume and intensity growth. For 1986-1992, the average annual growth in real GDP was 2.30% while the average growth in real volume and intensity (as measured by the Medicare Trustees) was 6.94%.

This proposal improperly assumes that the appropriate rate of growth for health care expenditures is GDP. This presumption simply flies in the face of the fact that the provision of health and medical care occurs in a highly service intensive sector of our economy where the labor and the

costs of services historically exceed the costs of goods. And, in truth, the costs associated with providing this care also should not be unexpected. These costs, much like educational expenses, historically have risen at a rate above the rate of growth in the GDP, the consumer price index, and other economic measures. Furthermore, the technology intensive nature of health care today and in the future acts as an accelerant and is a further significant reason why there is the gap between real GDP and real medical volume and intensity. This gap also represents a real demand for the services from which our patients benefit.

Nevertheless, the proposal arbitrarily would limit program growth leading to spending increases far below even nominal GDP growth. This proposal is unacceptable, especially when coupled with the OBRA 93 reduction in the performance standard rate of increase from 2% to 4% for 1995 and beyond. This proposal would eliminate any remaining shred of credibility for the MVPS as a reasonable guideline for the evaluation of spending on physician services.

Repeal of Restriction on Maximum Reduction Permitted in Default Update

The floor on MVPS payment reductions was an integral part of the OBRA 89 compromise. It served to protect physicians and patients from excessive and automatic application of the MVPS formula. Nevertheless, OBRA 93 just three months ago increased the maximum MVPS-related payment reduction from 3% to 5%. This change has already eroded the floor on MVPS-related adjustments that was an integral part of the OBRA 89 agreement. By the outright elimination of this floor, the other changes set out in the Administration's proposal would combine to wreak maximum havoc on physician payment reform.

Reduction in Conversion Factor for Physician Fee Schedule for 1995

Following on OBRA 93 reductions in the 1995 conversion factor, the Plan proposes even steeper reductions in the conversion factor update for non-primary care services in 1995. It would allow the full 1995 default update only for primary care services and would actually roll back the 1994 conversion factor levels by 3% for all other services.

Given that all indications are that 1993 actual Part B physicians spending will be well below the 1993 MVPS, especially for surgical services, it appears that this proposal will once again prevent physicians from realizing promised payment increases. This provision abrogates the agreement that created the MVPS, and it would be little more than a jump start to a future of diminishing real payments for services provided Medicare beneficiaries. Furthermore, as charges for services go down, demand can be expected to increase, further exacerbating this problem.

Limitations on Payment for Physicians' Services in High-Cost Hospital Medical Staffs

The Plan would create an elaborate scheme of hospital medical staff MVPSs. In general, this provision would require the Secretary of HHS to project a hospital-specific per admission relative value for the next year by October 1 of each year (beginning with 1997) for each hospital and to estimate whether or not this hospital-specific projected relative value will exceed the allowable average per admission relative value applicable to the hospital for the following year. The allowable average per admission relative value is set as a percentage of the median 1996 hospital-specific per admission relative value and is set differently for urban (120% for 2000 and beyond) and rural (140%) hospitals. It would be adjusted for case-mix, disproportionate share, and teaching status.

If any overage is projected, the Secretary would reduce all payments made for hospital inpatient services provided by physicians on that medical staff by 15%. Actual and projected shortfalls would not be reconciled until October 1 of the year after any reductions are made (i.e., October 1, 1999 for reductions made relating to services provided from January 1 - December 31, 1998). Where the actual average per admission relative value for the medical staff did not exceed the allowable average per admission relative value applicable to the medical staff, the Secretary would reimburse the medical staff for the amount by which payments were reduced.

Where reductions are made, and where the adjusted expenditures were less than 15% above the allowed level, the medical staff would not recoup the full amount by which its overage was less than 15%. If the shortfall is less than 10%, the Secretary would reimburse the medical staff for the difference between 10% and the actual percent by which the staff exceeds the limit—that is, if the medical staff exceeded the limit by 5%, it would be reimbursed 5% and would be penalized 10%. If the shortfall exceeds 10%, none of the withhold would be returned to the medical staff—that is, if the medical staff exceeded the limit by 10.1%, it would be penalized 4.9%.

- The AMA is very concerned by the many negative implications of this proposal. It would: violate the principle of simplicity by creating a new and onerous regulatory structure;
- require the Secretary to project hospital-level average relative values per admission and, based on these projections, would withhold the full 15% of all payments for medical care even if the projected overage is 1% or even .1% (The MVPS experience shows the limit of the nascent "science" of volume/intensity projections.);
- delay reconciliation until October 1 of the following year, even though relevant data would be available by April 1;
- make only partial repayment to physicians for excessive withholdings;
- establish specific standards for "high cost" medical staffs in advance of any provisions for public notice and comment;
- assume that DRG-based case mix adjustments were appropriate for physician payments;
- require medical staffs to establish expensive fiscal and administrative structures to monitor care using measures that may not be appropriate for such a purpose; and
- violate agreements on MVPS-structure that were made as a result of OBRA 93.

Finally, this proposal would shift both hospital and physician payment incentives to reward the provision of the least care. Physicians as well as other care givers should not be penalized for advocating care for their patients. This certainly violates the principles of security, responsibility, quality and choice.

Elimination of Medicare Balance Billing

The Administration proposes to impose mandatory assignment on all Medicare Part B claims as of January 1, 1996. The AMA strongly protests this change. Again, this is a major violation of the agreements reached in reforming physician payments under Medicare just 4 years ago. This also is inconsistent with the Physician Payment Review Commission's (PPRC) 1989 recommendations to the Congress. This change would exacerbate current cost shifting pressures. Also, as previously noted, this type of action will increase Part B spending as patient out-of-pocket costs are reduced.

RBRVS OVERHAUL

Section 4115 of the Plan, titled Medicare Incentives for Physicians to Provide Primary Care, proposes what can only be referred to as an "RBRVS overhaul." This provision addresses:

- Medicare payment for office consultations;
- payment for office visit work and practice expense relative value units (RVUs);
- resource-based RBRVS practice expense values; and
- payment for services with high ratios of work RVUs/time.

In general, these proposals manipulate the RBRVS to reach a predetermined outcome—a substantial increase in the Medicare payment levels for primary care services. (Under current law, primary care services include office visits, emergency department services, and several other categories of visits; they do not include consultations, hospital visits, or critical care.)

The AMA is committed to an RBRVS that is based on accurate measures of physicians' resource costs. We have made a major commitment to organize physician groups into a Relative Value Update Committee (RUC) in order to maintain the RBRVS's scientific validity. HCFA already relies on the RUC results in the RBRVS update process. (We would be pleased to provide further information on this activity for the Subcommittee and its staff.)

The RBRVS should be based on, and only on, accurate measures of physicians' resource costs. RVUs should not be revised solely to achieve inter-specialty payment goals. Relative value adjustments outside of the normal RUC and refinement processes, solely to achieve inter-specialty

payment redistributions, threaten the RBRVS and its continued viability, especially for use beyond Medicare. Finally, the AMA continues to have concerns about funding specific policy changes by reducing RBRVS RVUs. We continue to factor a separate Medicare Adjustment Factor to make such budget neutrality adjustments.

Resource-Based Practice Expenses

This proposal calls for the Secretary of HHS to increase practice expense (PE) RVUs for primary care services by 10% starting in 1996, with RVUs reduced for all other services by a budget neutral amount. It also calls on the Secretary to establish a resource-based PE method that could be implemented in 1997 and to report to Congress by June 30, 1996, on the methodology for this system, including a presentation of the data utilized in developing the methodology and an explanation of the methodology.

The AMA continues to support a PE study by the HHS Secretary. Prior to completion of the RBRVS transition in 1996 and without the results of this study, we oppose implementation of resource-based practice expense RVUs. Although a 10% increase in the primary care practice expense RVUs would be consistent with current projections of the PPRC's resource-based practice expense method, it would result in payment reductions for all other services regardless of whether the PE RVUs would increase or stay unchanged under the ultimate RBRVS PE methods. This proposal, on top of the just enacted OBRA 93 updates that favor primary care services, is premature.

Office Consultations

This proposal would cut Medicare payment rates for office consultations to equal those for office visits beginning in 1996. It would use resulting savings to increase payments for office visits. Under this proposal and based on 1993 national (no geographic adjustment) RBRVS amounts, it would be possible that payments for new patient office visits would increase by 5.5% and payments for office consultations would decrease by 23-31%. Medicare payments to specialties providing a substantial share of primary care services would rise—family physicians (2.1%), internists (.2%) and allergists (1.3%). Payments to other specialists, including cardiologists (-1.3%), gastroenterologists (-2.3%), and neurologists (-6.5%), would fall.

This provision would make large cuts in current consultation payments to fund small office visit increases, and it would be contrary to PPRC conclusions that consultations should have higher average work intensities.

Primary Care Work RVUs

This proposal would increase office visit work RVUs by 10% to "office visit pre- and post-time." The RVUs for all other services would be reduced to fund this change, as with the PE RVU increase. The assumption is that all pre/post-service time is not included in the current RBRVS values. We are concerned that the methodological or data basis for this change is unclear. Time needs to be reflected accurately by the RBRVS. For example, case management services and telephone consultations are not fully accounted for in pre/post time.

Reduce the Work RVUs of "Outlier Intensity" Procedures

Beginning in 1996, this proposal would require the Secretary to reduce the work RVUs for "outlier intensity" procedures, or classes of procedures, that have a high ratio of work RVUs per procedure time. "Savings" would be used to increase payments for primary care services. This proposal resembles the approach in OBRA 93 to reduce "outlier" PE RVUs. No specific threshold or level of reduction is suggested, nor is there a publicly available database with this information.

This proposal would simply assume that "outlier" intra-work RVUs are inappropriate, even though they were developed by the same Harvard RBRVS method used for the overall RBRVS and have not been altered by HCFA's refinement process. The AMA opposes such an arbitrary series of reductions outside a formal RVS update and refinement process. The RUC currently is working on methods that could be used to identify overvalued services. This proposal could distort the relative values for both outlier services and primary care services. It could also set a precedent for non budget-neutral reductions for other categories of "overvalued" services.

COMPETITIVE BIDDING

The "Health Security Act" calls for the use of competitive bidding as a mechanism to pay for various health and medical services. In addition to broad authority to determine what would be purchased through competitive bidding, the proposal specifically calls for this method to be used as the payment mechanism for MRI and CT scans (including physician interpretation), and clinical diagnostic laboratory services. If competitive bidding does not result in a 10% reduction in the fee schedule for clinical laboratory services, the Secretary would be required to reduce such fees to achieve the 10% reduction.

While competitive bidding may be appropriate as a purchasing mechanism for goods and services where quality is readily discerned or generally does not vary, it is wholly inappropriate for the purchase of professional services that are tailored to dynamic and highly individual needs. Competitive bidding is a particularly inappropriate mechanism to purchase medical and health care services, and it violates the principles of security, responsibility, quality and choice.

Where items are standardized or easily specified, such as nuts and bolts, competitive bidding is a logical mechanism for choosing the supplier of goods. However, where professional services are being purchased, even what appears to be a "standardized" service may not be so easy to quantify.

Competitive bidding may result in a reduction in the quality of and access to the service sought. The potential for reduced quality is particularly real in the health care sector of the economy where the services are unique due to many variables, including the involvement of individual patients, physicians, hospitals, and other health care providers.

While initial savings may be generated by competitive bidding, the savings may be counterbalanced by a loss in the quality of health care services and diminished access to care where the "winning" bidder is remote from the patient, or where "non-winners" cut back on their provision of the particular service. Such savings are short-sighted and carry the high potential for a negative health care outcome.

We continue to maintain that the competitive bidding mechanism for selecting a provider of such distinct and individual care services is just not appropriate. Serious questions that ultimately revolve around the quality of care provided readily arise:

- How would the quality of the provider bidding on the services be determined?
- Would providers be allowed to bid on services that are outside of their current area of service provision?
- Would turn-around time be affected by the bid price?
- Will patients be inconvenienced or costs increased if physicians are unable to provide or attain special services through their offices or other settings?
- Would the competitive bid process force losing competitors out of business, thereby limiting access to care?
- How is the bid area to be defined? What would be the impact of a national or regional provider of services on the bid? How would such a provider participate in the bid process?

In addition to the specific questions raised here, serious consideration must be given to the future of the health care industry in an area where a competitive bid demonstration is allowed. Under the current system, a large number of entities may deliver services, price information should be readily available, and physicians and their patients are free to elect to have services provided by one provider as opposed to another. Where there is dissatisfaction with the provider services, physicians and their patients should have the option of voting with their feet and going to a new provider. Under a competitive bid system, this ability will be either eliminated or greatly diminished. There has been some experience in this area with the competitive bidding of pap smears by some states. Unfortunately, the results were often poor quality. As a result, those contracts have been terminated.

Under a competitive bid program, dissatisfied beneficiaries are unable to exercise true freedom of choice. Eliminating freedom of choice eliminates a major quality check that oftentimes is a patient's or referring physician's only significant option in directing care: the ability to seek care from the complete range of physicians and other health care providers.

We urge rejection of competitive bidding as a means to purchase unique health and medical care services. Being a low bidder carries no guarantee of quality. In a truly competitive market, purchasers are free to elect to receive services from the provider of their choice. This would not be the case in a competitive bid environment and the end result is one where it is the potential recipient of the services who may suffer. Our patients stand to be the ultimate losers from such a direction.

CENTERS OF EXCELLENCE

President Clinton's proposed "Health Security Act" would provide the Secretary with broad authority to enter into contracts, using a competitive process, with "centers of excellence." This would be done for cataract surgery and for other services deemed appropriate by the Secretary. All payments made to such centers, including payment for physicians' and other professional services would be made directly to the center. The proposal is silent as to criteria for or the definition of "centers of excellence."

The AMA questions the feasibility of establishing "centers of excellence" using a competitive process as a way to either contain Medicare costs or improve quality. Several questions arise in considering the "centers of excellence" proposal:

- How many of these "Centers" will be established in a given geographical area?
- How far will Medicare beneficiaries be required to travel to receive health care services at these centers, and how will follow-up care be provided?
- If key individuals on the medical staff in one of these centers leave, does the center lose its "excellence" rating?
- If a Medicare beneficiary is unable or unwilling to receive care through a convenient "center of excellence" for a particular service, will reimbursement be denied?
- What happens if the best health care facility providing a specific health care service refuses to bid on being designated a "center of excellence"? Will Medicare beneficiaries be denied the services of this facility?

Furthermore, physicians who are not providing services through one of these "centers of excellence" and other non-designated facilities could be perceived by the public as providing poor quality services. This would be a serious misperception and an unfortunate result of establishing these "centers of excellence." The AMA believes that too many problems arise to justify establishing "centers of excellence" as a formal part of the Medicare program.

CONCLUSION

The American Medical Association regrets having to appear before you with so many negative comments about the President's proposal to restructure Medicare as part of health system reform. If the goal behind these Medicare proposals is to save money and to squeeze the program out of existence, then the Administration should be upfront and simply close down the program and "mainstream" the over 30 million Medicare beneficiaries.

We want the Subcommittee to know that physicians are eager to adapt to and participate in a revamped American health care system. However, change should be accomplished in a manner that builds on what works in our system without destroying it. Finally, we urge you to consider each of the multiple Medicare proposals in the context of security, simplicity, savings, responsibility, quality and choice. We just do not believe that the proposals before you today can pass this scrutiny.

Chairman STARK. Mr. Lewis.

**STATEMENT OF THOMAS J. LEWIS, SENIOR VICE-PRESIDENT
AND CHIEF EXECUTIVE OFFICER, THOMAS JEFFERSON UNI-
VERSITY HOSPITAL PHILADELPHIA, PA., ON BEHALF OF THE
AMERICAN HOSPITAL ASSOCIATION**

Mr. LEWIS. Thank you, Mr. Chairman. I am pleased to be here today on behalf of America's hospitals to discuss the treatment of Medicare in the context of health reform. For the record, I am not an association executive. I am the administrator at Jefferson Hospital in Philadelphia.

Jefferson is a medical school hospital of about 700 beds. We also serve as the primary teaching hospital for the College of Allied Health Sciences, and we have a Medicare activity level of about 37 percent and medical assistance of about 22 percent. We are a tertiary care hospital with a full range of services, including a spinal cord injury and trauma center.

We appreciate your dedication to moving the process of health reform forward, and I am not here today to suggest that it doesn't need to move forward. Certainly it does. Neither am I here to suggest that the hospitals should not be asked to participate actively in continuing to slow the growth of the health care expenditures. We should, and we are willing.

I would like to make two points, though, today. First with respect to the budget reductions, we are a little worried about the extent to which we are being asked to participate. Of the \$124 billion in Medicare reductions that we believe are in the President's plan, it appears that \$74 billion of those will come from hospitals. These reductions are unprecedented in their magnitude, and I believe could cause serious harm in many places, which is why we are so strongly opposed to them.

According to the Prospective Payment Assessment Commission's own figures, which were talked about earlier here today, over two-thirds of the Nation's hospitals are being reimbursed at only 88 percent of their costs for Medicare services on average. This is based on data which is 2 years old at this point, so for many the situation is even worse today.

The reductions as proposed are particularly damaging for institutions that provide services to large numbers of Medicare and medical assistance patients, thus academic medical centers like Jefferson and many teaching hospitals will be particularly hard hit. For example, a recent study done by a consulting group named Solon, S-O-L-O-N, for the National Association of Urban Critical Access Hospitals concluded that the average hospital will lose approximately 7 percent of their Medicare revenues annually over the next 5 years under the administration's plan. For Jefferson, we have projected that we would see about a \$10 million reduction in revenues in the first year of the plan.

It is hard for me to imagine how some of these institutions are going to deal with that kind of a reduction, particularly in light of the kind of cost reduction activities and restructuring that have been going on in the health care industry in the last couple of years.

The bottom line, if you will, is that putting this kind of pressure on the infrastructure of our health care system particularly when we are trying to rebuild it is asking for problems, and I am afraid that these problems may come in the form of reduced quality in the delivery of services. Clearly, if we are to achieve further efficiencies in Medicare, our best hope is to reorganize the delivery system.

What we and the AHA are talking about are accountable health plans which are locally based organizations, are paid on a capitated basis and held publicly accountable to their communities. We believe they have the potential of providing for an integrated delivery system that will—that could be the foundation of a restructured delivery system.

The second area that I would like to address briefly is the treatment of Medicare in the context of this restructured delivery system. America's hospitals believe that leaving Medicare out of the new delivery system constitutes a halfhearted attempt at reform, particularly when you consider that the program comprises nearly 40 percent of the average hospital's revenues. That is not to say that we believe that Medicare should not retain its own identity. We believe that it should, but there are two key issues that we think need to be addressed.

First, by leaving the Medicare program out of the reform, we will continue to have to deal with conflicting incentives. For the Medicare patients, providers would be under the old system with incentives to provide more acute care services related to volume-related incentives, while on the other side a provider would be under a new purchasing alliance or accountable health plan that we would hope would create incentives to promote health and reduce acute care encounters.

Second, hospitals with large Medicare populations may be at an enormous disadvantage as this health system reform takes place in the sense that they will have two options, they will either be able to be a part of an accountable health plan or local system or a vendor to an accountable health plan. In either case, they will be put at a disadvantage, we believe.

In the final analysis, as we move forward with the health reform, we think that we need to be sure that the providers and the beneficiaries have the same and consistent incentives to contain costs and to better utilize health resources.

I appreciate the opportunity to be here today, and we look forward to continuing to work with this committee as health reform moves forward. Thank you.

[The prepared statement and attachments follow:]

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Statement
of the
American Hospital Association
before the
Subcommittee on Health
of the
Committee on Ways and Means
of the
United States House of Representatives
on
The President's Health Care Reform Proposals:
Changes to the Medicare Program

November 23, 1993

Mr. Chairman, my name is Thomas J. Lewis, senior vice-president and chief executive officer of Thomas Jefferson University Hospital in Philadelphia, Pennsylvania. On behalf of the American Hospital Association and its 5,300 institutional members, I am pleased to testify today on proposed Medicare spending reductions in the President's health care reform plan and the integration of Medicare into a reformed health care system.

THE TIME FOR REFORM IS NOW

America's hospitals believe that now is the time to reform our health care system. President and Mrs. Clinton raised the curtain and put reform under the national spotlight. You and the members of your subcommittee have played -- and will continue to play -- a valuable role in making reform a reality. But our time in the spotlight is often fleeting, and if we don't act now, another opportunity to reform health care may not appear for decades.

In acting promptly, we must not act unwisely. In our zeal to build a better health care system, we must keep our eyes on the long-range goal of creating a reformed health care system that efficiently serves all Americans. Purely budget-driven decisions can make our nation's health-care problems worse, and can stall the drive toward effective reform.

If we want to achieve fundamental, workable reform, two things are clear. One, we should not be taking big chunks of resources out of a program -- Medicare -- that must be part of the foundation of reform. And two, Medicare must operate under the same reform principles as the rest of the health care economy.

MEDICARE REDUCTIONS

The Administration's proposed reductions of \$124 billion in future Medicare spending would chip away at the foundation of care for America's elderly. Such unprecedented reductions would be unwise policy anytime, but would be especially dangerous as we attempt to reform our health care delivery system. In addition, the effects of these reductions would be compounded by the \$56 billion already cut from Medicare in the last budget round -- on top of \$43 billion included in the Omnibus Budget Reconciliation Act (OBRA) of 1990.

Based on the information available to date, about \$105 billion of the Administration's proposed \$124 billion in total Medicare reductions would come from lower payments to providers -- and \$74 billion of that would come from hospitals. We certainly agree with the nation's need to slow health care spending growth. And, we support the added benefits intended for Medicare patients -- prescription drugs and long-term care. But, we cannot support underpaying hospitals in order to pay for these benefits.

Providing universal coverage is not cost-free. Expanding the covered population, restructuring the health care system, reconfiguring hospitals and other services for the future, and investing in new technologies to meet the demands of the new system -- all will need adequate resources. For example, the infrastructure improvements we all endorse in order to reduce administrative costs -- electronic billing, computerized patient records, new information systems -- require an up-front investment. Reaping the benefits of these efficiencies will not happen overnight. But they will never materialize if we don't invest adequate resources now.

Hospitals are key to the health care infrastructure. In building upon that infrastructure, we should not weaken its foundation. Furthermore, hospitals' ability to get beyond the traditional hospital acute care role that will be necessary under reform would be jeopardized by excessive spending reductions. For example, consumer education, wellness, and outreach programs -- not funded by the current system -- are among the most vulnerable when finances are squeezed.

OBRA 1993 reductions compound the problem

It is also important to remember what happened earlier this year in OBRA 1993 (P.L. 103-66) -- \$24 billion of the \$56 billion in Medicare reductions came from hospital care for the elderly. Most of these reductions will take effect in the out-years of 1996-1998. Stripping another \$74 billion from Medicare hospital payments adds up to a total of \$98 billion in reductions (see attachment 1). Moreover, the impact grows rapidly in later years. Such a huge alteration in Medicare spending is larger than the hospital community has ever sustained, and is simply too big a risk to take.

Yes, we're concerned about the impact on hospitals. But hospitals take care of people. They exist in communities and are operated by enormously skilled and dedicated people. Particularly hard-hit would be facilities that treat large numbers of low-income patients -- Medicare disproportionate-share hospitals -- that would lose about \$15 billion. Teaching hospitals -- whose mission will be the training of the primary care physicians who are such an integral part of a reformed health care system -- are slated for nearly \$18 billion in reductions over five years.

And let's be candid. You can't affect human institutions without affecting human beings in some way. The Administration's proposed Part A hospital spending reductions per Medicare enrollee would total more than \$555 per individual in the year 2000. That's an 11 percent reduction in Medicare Part A benefits paid per enrollee in a single year (see attachment 2).

In the year 2000, hospitals would have nearly \$1,600 fewer dollars per admission to care for Medicare patients -- that's 16 percent less per Medicare admission in a single year. In 1991, overall Medicare payment fell 12 percent short of meeting hospitals' costs for those patients (see attachment 3). That's why two-thirds of the nation's hospitals must subsidize the cost of treating Medicare patients in fiscal 1993. Many of these hospitals are the source of health care for poor, elderly, and rural Americans. Reduce Medicare resources and you create huge gulfs between payments and costs for these hospitals. This is simply unsustainable.

Just looking at the way hospitals are forced to make up for Medicare and Medicaid shortfalls today should throw up a red flag for the future. Hospitals today must compensate for payment shortfalls by attempting to reduce costs and by raising charges to private-sector patients. But the Administration's plan would limit private sector premium increases -- effectively precluding such cost-shifting in the future.

If private sector premium increases are limited and cost-shifting is precluded, hospitals' ability to compensate for payment shortfalls will be limited -- because their ability to significantly reduce costs in the current delivery system is limited. As the Prospective Payment Assessment Commission recently reported, 60 percent of hospital cost increases from 1985 to 1989 were due to factors beyond hospitals' control -- inflation in the general economy (39 percent) and increasing complexity of patients treated (21 percent) (see attachment 4).

The primary ways in which hospitals can control costs are unpalatable: reduce the size of the hospital work force, or reduce services and programs -- or both. Hospitals are reluctant to reduce their work force, because doing so jeopardizes their ability to do their job well -- hospitals are very labor-intensive facilities. Similarly, it is often easier to eliminate certain services than to restructure services in order to cross-subsidize care. Hospitals will continue to work to provide care more efficiently. But, given these economic facts of life, additional Medicare payment reductions would be felt more deeply than ever by hospitals.

We should also remember that the Part A trust fund is financed through a payroll tax dedicated to pay for Medicare Part A benefits only. Raiding this trust fund to provide Part B benefits, or to finance a lion's share of broader health care reform, is unwise health care policy as well as unwise federal fiscal policy. Money flowing into this dedicated trust fund finances a specific set of benefits -- benefits that would be threatened if the trust fund is sacrificed to other purposes.

AHA recommendations

What do we recommend? We believe that health care reform should be financed in a broad-based manner. This includes three components:

- 1) Use the estimated \$58 billion in savings and taxes now targeted toward deficit reduction to help finance the health care reform effort.
- 2) Look for alternative funding sources, such as increasing "sin taxes" and limiting employer/employee tax deductibility for health care coverage. And, because the Administration plan creates new entitlement subsidies for many individuals and small businesses who may be able to afford coverage on their own, savings could be achieved by income-testing these subsidies.
- 3) Instead of ratcheting down the current volume-driven delivery system, reform the way patients receive care by restructuring the health care delivery system to stimulate both effectiveness and efficiency.

MEDICARE INTEGRATION

This brings me to a second issue that AHA believes is critical to any discussion of reform: the integration of Medicare into a reformed health care system.

What do we mean by integration? We believe it's absolutely essential that the Medicare population be part of the same reformed system as other Americans. It is also essential that providers' incentives are the same, no matter who sponsors a patient's care, to promote more efficient and cost-effective care. Medicare patients account for 40 percent of a typical hospital's revenues. Imagine trying to run an efficient hospital if nearly half of what you do is driven by one set of financial incentives, and the other by entirely different -- in fact, exactly opposite -- incentives. That's a formula for chaos if there ever was one.

But that's just what will happen if Medicare patients remain outside the reform tent. Patients in the reformed health care system will have a financial incentive to purchase coverage from cost-effective providers. And those providers will have an incentive to use services wisely, because inappropriate use reduces the funds available for other purposes. Shouldn't Medicare beneficiaries have strong incentives to seek cost-effective care and their providers have consistent incentives to treat them in the most cost-effective way?

Provider cooperation, integration threatened

For hospitals, this two-pronged approach just doesn't make sense. First, it undermines both the financial and administrative incentives to form the kind of cooperative provider partnerships and networks that will produce more cost-effective care. For example, keeping Medicare beneficiaries in traditional fee-for-service arrangements with all their conflicting incentives means that demonstrated cost savings that come from paying providers an annual fixed fee to care for an enrolled group of patients just won't happen for this important patient group. Such

capitated payment provides incentives for all providers to treat patients in the most cost-effective way. And that means better primary and preventive care that saves us money in the long run.

The two-pronged payment system envisioned in the Administration's plan has another significant flaw. It disadvantages those hospitals serving a disproportionate share of Medicare patients. Given Medicare's historic underpayment record, made much worse by the reductions proposed in the Administration's legislation, these institutions would be severely crippled in their efforts to become part of a reformed health care system. Hospitals with high Medicare volume, for instance, could be financially unattractive to potential partners as local provider networks are formed. And, they simply wouldn't have the resources to do the reconfiguring and outreach that is going to be necessary as we move from today's flawed system to tomorrow's better one.

Changes needed in regional alliances

We are not, however, calling for Medicare beneficiaries to be included in regional alliances. We are concerned about the structure of these alliances -- we feel they are too big and too complex. Plus, they have to work right from Day One of reform -- a tall order for an entity that doesn't even exist today. We would like to see the alliances scaled back to the original concept of purchasing cooperatives for small employers.

Incentives for cost-effectiveness needed for all patients

While we don't advocate including Medicare beneficiaries in regional alliances, we do believe Congress must provide greater incentives for beneficiaries to enroll in the managed care plans currently available under Medicare. Today, fewer than 5 percent of beneficiaries are enrolled in an HMO or other plan that receives a capitated payment from Medicare. Increasing the number of beneficiaries enrolled in capitated plans is important so that providers in those plans will have the same incentives to provide the kind of cost-efficient care that will be required in the restructured delivery system as envisioned by the Administration, the AHA, and others.

We have identified a number of options that we believe could increase enrollment in Medicare managed care arrangements. These include:

- Option 1 --** Make managed care arrangements less expensive than a fee-for-service option by waiving a current cost paid by Medicare beneficiaries -- for example, deductibles, copayments, or a limit on inpatient days.
- Option 2 --** Offer benefits in a managed care arrangement that are currently excluded from Medicare coverage -- such as prescription drugs, long-term care, or more preventive services.
- Option 3 --** Offer a point-of-service option in Medicare managed care arrangements. Today, providers who treat Medicare patients can be paid either on a fee-for-service or a capitated basis. This option give enrollees a third choice: to "opt out" of the capitated payment arrangement, for a single episode of care, at any time to see a provider of their choice -- but at a higher cost to the beneficiary. This opens to Medicare beneficiaries the same care and payment options currently available to other Americans.

Any of these options must be linked to a vigorous effort to educate older Americans about the advantages of such plans and the satisfaction of those who use them. We see providing incentives for Medicare beneficiaries to choose managed care arrangements as being consistent with the restructuring of the health care delivery system into health plans -- we call them "community care networks."¹⁰ They are the cornerstone of AHA's health reform vision. These collaborative networks would include hospitals, doctors, insurers and other health-care providers. They would evolve over time to provide a broad, coordinated continuum of care with a focus on improving the health of the enrollees and the larger community. In return, networks would be paid a fixed annual fee per enrollee. The allocation of resources among the providers in the network, including the method and level of payment, would be determined within each network.

Such networks would give providers greater freedom to make decisions based on the needs of the community rather than micromanagement by insurers and government-payers. Community care networks would result in a simpler, more efficient, effective, and less expensive system for all Americans -- including Medicare beneficiaries.

CONCLUSION

Mr. Chairman, hospitals, on the front line of health care delivery, feel we also have a place on the front line of reform -- just as you and your colleagues do. We value the working relationship we have built with you on this issue, and we look forward to working with you further as we help build a new health care system for America's future.

¹¹ -- CCN, Inc. and San Diego Community Health Alliance use the name Community Care Network as their service mark and reserve all rights.

MORE REDUCTIONS IN MEDICARE HOSPITAL SPENDING

**PRESIDENT'S PROPOSAL TO REDUCE MEDICARE HOSPITAL SPENDING IS
IN ADDITION TO SPENDING REDUCTIONS ALREADY TAKEN IN
THE OMNIBUS BUDGET RECONCILIATION ACT OF 1993 (OBRA 1993)**

ANNUAL MEDICARE HOSPITAL SPENDING REDUCTIONS: OBRA 1993 AND THE PRESIDENT'S PROPOSAL FOR HEALTH CARE REFORM (By fiscal year, in billions of dollars)								
	1994	1995	1996	1997	1998	1999	2000	TOTAL
OBRA 1993 ¹	\$ 0.8	\$ 2.8	\$ 5.5	\$ 7.0	\$ 7.8	\$?? ³	\$?? ³	\$ 23.9
CLINTON PROPOSAL ²	\$ 0.2	\$ 1.1	\$ 5.2	\$ 8.5	\$ 14.3	\$ 19.6	\$ 25.2	\$ 74.1
TOTAL	\$ 1.0	\$ 3.9	\$ 10.7	\$ 15.5	\$ 22.1	\$ 19.6 ⁴	\$ 25.2 ⁴	\$ 98.0

1 Source: Congressional Budget Office

2 Source: Clinton Administration, November 18, 1993

3 The Congressional Budget Office did not estimate the budgetary impact of OBRA beyond 1998. Spending reductions, however, will continue in 1999, 2000 and beyond.

4 Total Medicare hospital spending reductions in these years do not include estimates for the impact of OBRA 1993 (see note above).

**LOWER MEDICARE PART A HOSPITAL PAYMENTS
PER ENROLLEE AND PER ADMISSION**

IMPACT OF THE PRESIDENT'S PROPOSED MEDICARE PART A HOSPITAL SPENDING REDUCTIONS					
	1996	1997	1998	1999	2000
President's proposed Medicare Part A hospital reductions (in billions of \$) ¹	\$ 3.9	\$ 6.8	\$ 12.1	\$ 16.9	\$ 21.7
Medicare HI enrollees (in millions) ²	37.0	37.5	38.0	38.5	39.0
Proposed Medicare Part A hospital reductions per Medicare HI enrollee	\$106	\$182	\$319	\$438	\$556
Percent reduction in annual Medicare Part A benefits per enrollee ³	3 %	5 %	8 %	10 %	11 %
Medicare hospital admissions (in millions) ⁴	13	13	13	13	14
Proposed Medicare Part A hospital reductions per Medicare hospital admission	\$310	\$529	\$922	\$1262	\$1596
Percent reduction in Medicare Part A hospital payments per admission ⁵	4 %	6 %	10 %	13 %	16 %

1 Source: Clinton Administration, November 18, 1993.

2 Source: Congressional Budget Office August baseline estimates 1996 through 1998. American Hospital Association estimates 1999 through 2000.

3 Source: American Hospital Association estimates of Medicare benefit payments per enrollee extrapolated from Health Care Financing Administration data through 1995 in *1993 Green Book*, p. 138.

4 Source: American Hospital Association estimates extrapolated from National Hospital Panel survey data through 1992.

5 Source: American Hospital Association estimates of Medicare hospital payments per admission extrapolated from Medicare cost report data.

Table 5-3. Hospital Payments by Source, by State Averages, 1991 (In Percent)

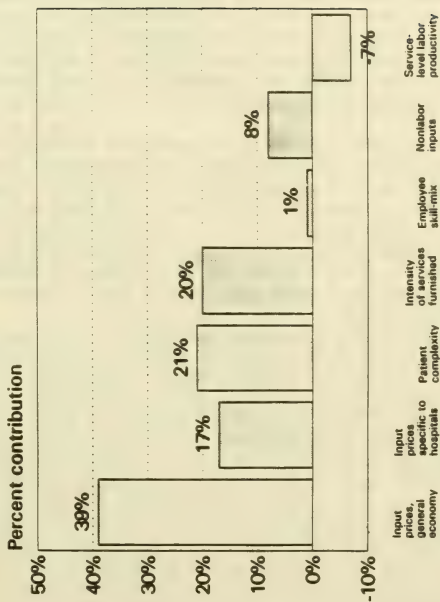
State	Payments as a Percentage of Costs			Uncompensated Care Losses as a Percentage of Total Costs
	Private Insurers	Medicare	Medicaid	
U S total	130%	88%	82%	4.8%
New York	107	95	89	3.5
Maryland	108	106	107	7.1
Rhode Island	108	99	91	3.3
New Jersey	111	98	119	8.9
Wyoming	111	86	94	3.1
Minnesota	114	92	84	1.9
Michigan	118	90	85	2.7
Massachusetts	120	94	89	5.8
Wisconsin	123	94	77	2.8
Arizona	124	94	80	4.0
Utah	124	87	88	3.5
North Dakota	124	88	96	2.2
Washington	124	100	82	3.3
Pennsylvania	126	90	74	2.7
Iowa	128	88	92	1.5
Oregon	128	96	65	5.3
District of Columbia	128	89	80	6.6
Ohio	128	87	90	4.0
Vermont	129	90	88	4.3
Kansas	130	88	82	3.5
Colorado	133	89	78	4.6
New Mexico	134	93	86	7.2
South Dakota	134	88	86	2.8
California	134	88	67	3.9
Montana	135	91	87	3.7
Maine	135	82	87	5.2
Indiana	136	85	99	4.8
Idaho	136	91	77	4.2
Missouri	137	87	77	5.3
Illinois	137	86	58	3.4
Nebraska	138	83	73	2.3
New Hampshire	138	83	90	5.8
Kentucky	138	90	99	4.9
Oklahoma	139	87	92	6.0
Texas	140	87	78	7.4
Connecticut	141	83	65	4.8
Virginia	142	90	73	6.2
Alabama	142	94	78	7.5
Georgia	142	87	88	7.5
West Virginia	142	90	85	7.3
Tennessee	143	87	82	6.1
Louisiana	144	87	87	3.8
North Carolina	145	89	85	5.8
Florida	146	84	82	7.7
Nevada	152	88	60	9.0
South Carolina	152	84	103	7.1
Mississippi	155	94	108	9.9
Arkansas	158	94	83	9.3

Note: In the first three columns, the payment received from each payer is shown as a percent of the cost of treating its patients. Uncompensated care losses (net of operating subsidies from state and local governments) are shown as a percent of costs across all payers. Alaska, Delaware, and Nevada omitted due to insufficient data being available.

SOURCE: ProPAC analysis of Annual Survey data from the American Hospital Association.

Taken from: Prospective Payment Assessment Commission, *Medicare and the American Health Care System, Report to Congress, June 1993*

Seven Factors Contributing to Hospital Cost Inflation 1985-1989



Source: ProPAC staff analysis
Health Affairs Vol. 11, No. 2, Summer 1992

Chairman STARK. Dr. Walton.

STATEMENT OF TRACY M. WALTON, JR., M.D., PRESIDENT-ELECT, NATIONAL MEDICAL ASSOCIATION

Dr. WALTON. Thank you, Mr. Chairman.

Mr. Chairman, I come today as a practitioner in wards 7 and 8 of the District of Columbia for over 20 years, a former chairman of the department of radiology at the District of Columbia General Hospital, and currently a medical educator at the University of the District of Columbia. I come today representing the National Medical Association as its President-elect and the National Medical Association is the largest predominantly African-American professional association in the United States which will celebrate its centennial in 1995.

We have a proud history of advocacy for African Americans and other minority groups regardless of socioeconomic status. We were, in fact, one of the few, if not the only, physicians' organization that supported the enactment of Medicaid and Medicare in the 1960s, and we are committed to health care reform today. We applaud the President's leadership in this regard. We also intend to work closely with the Congress in developing health care reform legislation that will benefit Medicare recipients in equal measure with others in the United States.

Today, you have asked us to focus on the President's health care reform package and the effect it will have on the Medicare program. Medicare is the Nation's largest health care program with expenditures equal to 2.4 percent of the gross domestic product, and 9 percent of Federal expenditures. Since the passage of Medicaid and Medicare in 1965, many have thought that the elderly, disabled, and the poor would be covered. Most estimates, however, project that 37 million Americans lack public or private coverage. In 1987, a national medical expenditure survey found that 47.8 million people lacked insurance for all or part of that year.

OBRA 93 includes \$55.8 billion in Medicare spending reductions over the next 5 years. This would be achieved through reductions in inflation allowances for provider reimbursement along with a continuation of current law policy of setting the part B premium at a level to cover 25 percent of program costs.

On the President's health reform proposal, those eligible for Medicare will automatically qualify for prescription drug coverage when they enroll in part B, which covers physicians' visits and other outpatient services. The President's plan estimates premiums under part B will increase by approximately \$11 to cover the cost of this benefit. There will also be a \$250 deductible per person per year, and Medicare recipients will pay 20 percent of the cost of each prescription. The maximum a person would have to pay would be \$1,000 over 1 year.

Our recommendations are that under the President's plan relating to part A that there is reduction of indirect medical education and permanent reduction in prospective Federal and hospital specific rates for capital. These cuts do not take into consideration how it will affect minorities and underserved populations.

The President's proposal relating to part B establishes cumulative expenditure goals for physician services and replacement of

the current use of historical volume and intensity and the default Medicare volume performance standard formula with per capita growth in real gross domestic product, plus 1.5 percentage points for primary care services. There should, however, be an adjustment for diagnosis according to the severity of the illness.

The President's plan establishes limits on payments to physicians of high cost hospital staffs. There should be a sliding scale that accommodates minority doctors and is culturally representative and sensitive.

The President's plan establishes centers of excellence. Minority institutions should be specifically mentioned as centers of excellence, particularly Howard University Hospital, which is located here in Washington, D.C., is the first center of excellence for liver transplants in this area.

The prospect that a fixed tax rate of 2.9 percent will sustain part A indefinitely and that part B will be allowed to double every 5 years is doubtful. At current growth rates, part B would be larger than part A in about 10 years, and part A and part B together could be larger than Social Security by the year 2010. The health care needs of today's elderly, disabled, and poor are too urgent to be held hostage by uncertain projections.

With regard to civil monetary penalties, the President's plan proposes raising penalties from \$2,000 to \$10,000. Such fines are excessive and extreme and should be closely monitored given that medical fraud investigations have disproportionately been directed toward African American providers in the recent past.

The President's proposals call for reductions in adjustment for indirect medical education. Such action would have a negative impact on public hospitals and historically black colleges and universities because it would be difficult to train residents. In addition, the overall fees for physicians would be decreased.

Additionally, we are pleased to share with you the National Medical Association's position on other areas of the Health Security Act and offer the following observations: We applaud the President's commitment to universal coverage. We also strongly support making health care coverage available without consideration of pre-existing health conditions.

We are pleased that AFDC/SSI recipients will not lose any currently mandated benefits, and that special provisions are made for the provision of all medically necessary items and services for children not included in the comprehensive benefit package. We are equally pleased that no premiums are required for AFDC/SSI families.

The National Medical Association applauds the availability of grants and contracts for those serving the most needy and medically underserved. We are concerned about the 5 year limitation on participation by essential community providers and urge that it be stricken in light of the important role this group would play in serving Medicare and Medicaid and low-income recipients.

We are concerned that AFDC/SSI families are expected to pay 20 percent of all amounts listed in the copayment schedule. Currently all services are received by these families with no payment at the point of service. Provisions must be made to phase in this require-

ment, and in cases where copayment would prevent the provision of necessary care, the payment provision should be eliminated.

We are concerned that low cost/high cost sharing schedules actually translate into a two-tier system. As with our current system, those with the ability to pay will receive the greater care. When large numbers of indigent patients whose health status is the poorest are funneled into the low cost sharing plan, system overload and declining quality of care will result.

We are concerned that decisions made about income verification and premium discounts will be made by the regional alliance, yet there are no provisions for proportional representation of ethnic minorities or the representation of consumers, particularly the low-income consumers at that level.

The National Medical Association opposes the limitation of membership of the board of directors of regional alliances, which as currently written would be composed of employers whose employees purchase health coverage through the alliance and members who represent individuals who purchase such coverage. Health care providers who are in the best position to advocate for the health needs of Medicaid and Medicare recipients are specifically prevented from participating on these boards.

We are concerned about financing and strongly oppose any spending reductions in Medicare. Medicare funds must not be used to finance health care reform. Instead, the program must be restructured to provide adequate coverage for these recipients.

The NMA has endorsed taxes on alcohol and firearms as fair and appropriate revenue sources. We are concerned that the sliding scale for adjustment of premium discounts applies to a family adjusted income above 150 percent of the poverty level. In fact, there is a graduated phaseout of the discount up to 150 percent of the poverty level. This is a very low threshold.

We are concerned that provisions are not made for a mechanism for adults (children are already covered) whereby uncovered medically necessary benefits may be granted.

We are concerned that convenient hospital and health professionals are currently not certified as essential community providers. Public hospitals and clinics are the essential community providers for Medicare recipients right now.

The NMA urges the provision of grants to States for educational services which are culturally sensitive and culturally competent. Organizations which are multidisciplinary and community-based should be charged with educating the newly insured on accessing the health care delivery system.

The National Medical Association recognizes the necessity to gain control of the health care crisis in this country. While revamping the Medicare programs, one which pays for medical care for many of the Nation's elderly, disabled and poor, we must remain cognizant of the accomplishments of this program in providing access to medical care for the poor.

Available evidence suggests that Medicare has been far more valuable than is commonly realized. It has served a broad cross-section of the American people, and its adoption coincides with significant improvements in the health status of Americans. Not widely recognized is the program's importance to the financial well-being,

if not to the very survival, of many major teaching hospitals and the majority of nursing homes in this country.

Mr. Chairman and members of the committee, the National Medical Association is committed to working with government decisionmakers and leaders of private and professional organizations in formulating health care policy which must benefit Medicaid and Medicare recipients and persons of low income.

Thank you for allowing the National Medical Association to help ensure that the special needs of the unserved, the underserved, and the underrepresented members of our population are addressed by health reform initiatives. Thank you very much.

Chairman STARK. Thank you.

[The prepared statement follows:]

TESTIMONY OF TRACY M. WALTON, Jr., M.D.
NATIONAL MEDICAL ASSOCIATION

CHAIRMAN STARK, MEMBERS OF THE COMMITTEE, I AM PLEASED TO JOIN YOU TODAY ON BEHALF OF THE NATIONAL MEDICAL ASSOCIATION ("NMA"). I AM DR. TRACY WALTON, PRESIDENT-ELECT OF THE NMA AND A PRACTICING PHYSICIAN IN RADIOLOGY FOR OVER 20 YEARS AS WELL AS A MEDICAL EDUCATOR AT THE UNIVERSITY OF THE DISTRICT OF COLUMBIA.

MY TESTIMONY TODAY IS ON BEHALF OF THE NMA, THE OLDEST AFRICAN AMERICAN PROFESSIONAL ASSOCIATION IN THE UNITED STATES WHICH WILL CELEBRATE ITS CENTENNIAL IN 1995. WE HAVE A PROUD HISTORY OF ADVOCACY FOR AFRICAN AMERICAN AND OTHER MINORITY GROUPS REGARDLESS OF SOCIO-ECONOMIC STATUS. WE WERE IN FACT, ONE OF THE FEW IF NOT THE ONLY PHYSICIAN'S ORGANIZATION THAT SUPPORTED THE ENACTMENT OF MEDICAID AND MEDICARE IN THE 1960's AND WE ARE COMMITTED TO HEALTH CARE REFORM TODAY. WE APPLAUD THE PRESIDENT'S LEADERSHIP IN THIS REGARD. WE ALSO INTEND TO WORK WITH THE CONGRESS IN DEVELOPING HEALTH CARE REFORM LEGISLATION THAT WILL BENEFIT MEDICARE RECIPIENTS IN EQUAL MEASURE WITH OTHERS IN THE UNITED STATES.

TODAY YOU HAVE ASKED US TO FOCUS ON THE PRESIDENT'S HEALTH CARE REFORM PACKAGE AND THE EFFECT IT WILL HAVE TO THE MEDICARE PROGRAM. AS YOU KNOW, MEDICARE IS THE NATION'S LARGEST HEALTH CARE PROGRAM WITH EXPENDITURES EQUAL TO 2.4 PERCENT OF THE GROSS DOMESTIC PRODUCT ("GDP") AND 9 PERCENT OF FEDERAL EXPENDITURES. SINCE THE PASSAGE OF MEDICAID AND MEDICARE IN 1965, MANY HAVE THOUGHT THAT THE ELDERLY, DISABLED AND POOR WOULD BE COVERED. MOST ESTIMATES, HOWEVER, PROJECT THAT 37 MILLION AMERICANS LACK PUBLIC OR PRIVATE COVERAGE. IN 1987, A NATIONAL MEDICAL EXPENDITURE SURVEY FOUND THAT 47.8 MILLION PEOPLE LACKED INSURANCE FOR ALL OR PART OF THAT YEAR.

AS YOU KNOW, ON AUGUST 10TH THE PRESIDENT SIGNED INTO PUBLIC LAW THE OMNIBUS RECONCILIATION BUDGET ACT OF 1993 WHICH INCLUDES \$55.8 BILLION IN MEDICARE SPENDING REDUCTIONS OVER THE NEXT FIVE YEARS. THIS WOULD BE ACHIEVED THROUGH REDUCTIONS IN INFLATION

ALLOWANCES FOR PROVIDER REIMBURSEMENT ALONG WITH A CONTINUATION OF CURRENT LAW POLICY OF SETTING THE PART B PREMIUM AT A LEVEL TO COVER 25 PERCENT OF PROGRAM COST.

UNDER THE PRESIDENT'S HEALTH REFORM PROPOSAL, THOSE ELIGIBLE FOR MEDICARE WILL AUTOMATICALLY QUALIFY FOR PRESCRIPTION DRUG COVERAGE WHEN THEY ENROLL IN PART B WHICH COVERS PHYSICIAN VISITS AND OTHER OUTPATIENT SERVICES. THE PRESIDENT'S PLAN ESTIMATES PREMIUMS UNDER PART B WILL INCREASE BY APPROXIMATELY \$11 TO COVER THE COST OF THIS BENEFIT. THERE WILL BE A \$250 DEDUCTIBLE PER PERSON AND MEDICARE RECIPIENTS WILL PAY 20 PERCENT FOR THE COST OF EACH PRESCRIPTION. THE MAXIMUM A PERSON WOULD HAVE TO PAY WOULD BE \$1,000 OVER ONE YEAR.

RECOMMENDATIONS

1. UNDER THE PRESIDENT'S PLAN RELATING TO PART A, THERE IS REDUCTION OF INDIRECT MEDICAL EDUCATION AND PERMANENT REDUCTION IN PERSPECTIVE FEDERAL AND HOSPITAL SPECIFIC RATES FOR CAPITAL. THESE CUTS DO NOT TAKE INTO CONSIDERATION HOW IT WILL EFFECT MINORITIES AND UNDERSERVED POPULATIONS.

2. THE PRESIDENT'S PROPOSAL RELATING TO PART B ESTABLISHES CUMULATIVE EXPENDITURE GOALS FOR PHYSICIANS SERVICES, AND REPLACEMENT OF THE CURRENT USE OF HISTORICAL VOLUME AND INTENSITY IN THE DEFAULT MEDICARE VOLUME PERFORMANCE STANDARD FORMULA WITH PER CAPITA GROWTH IN REAL GROSS DOMESTIC PRODUCT (PLUS 1.5 PERCENTAGE POINTS FOR PRIMARY CARE SERVICES). THERE SHOULD, HOWEVER, BE AN ADJUSTMENT FOR DIAGNOSIS ACCORDING TO THE SEVERITY OF THE ILLNESS.

3. THE PRESIDENT'S PLAN ESTABLISHES LIMITS ON PAYMENTS TO PHYSICIANS OF HIGH COST HOSPITAL STAFFS. THERE SHOULD BE A SLIDING SCALE THAT ACCOMMODATES MINORITY DOCTORS AND IS CULTURALLY REPRESENTATIVE AND SENSITIVE.

4. THE PRESIDENT'S PLAN ESTABLISHES "CENTERS OF EXCELLENCE". MINORITY INSTITUTIONS SHOULD BE SPECIFICALLY MENTIONED AS CENTERS OF EXCELLENCE (E.G., HOWARD UNIVERSITY HOSPITAL LOCATED IN WASHINGTON, D.C. IS THE FIRST CENTER OF EXCELLENCE FOR LIVER TRANSPLANTS IN THE AREA.

5. MOST WOULD AGREE THAT THE PROSPECT THAT A FIXED TAX RATE OF 2.9 PERCENT WILL SUSTAIN PART A INDEFINITELY AND THAT PART B WILL BE ALLOWED TO DOUBLE EVERY 5 YEARS IS DOUBTFUL. AT CURRENT GROWTH RATES, PART B WOULD BE LARGER THAN PART A IN ABOUT 10 YEARS AND PART A AND PART B TOGETHER COULD BE LARGER THAN SOCIAL SECURITY BY THE YEAR 2010. THE HEALTH CARE NEEDS OF TODAY'S ELDERLY, DISABLED AND POOR ARE TOO URGENT TO BE HELD HOSTAGE BY UNCERTAIN PROJECTIONS.

6. WITH REGARD TO CIVIL MONETARY PENALTIES, THE PRESIDENT'S PLAN PROPOSES RAISING PENALTIES FROM \$2,000 TO \$10,000. SUCH FINES ARE EXCESSIVE AND EXTREME AND SHOULD BE CLOSELY MONITORED GIVEN THAT MEDICAL FRAUD HAS BEEN DISPROPORTIONATELY DIRECTED TOWARD AFRICAN-AMERICAN PROVIDERS.

7. THE PRESIDENTS PROPOSAL CALL FOR REDUCTIONS IN ADJUSTMENT FOR INDIRECT MEDICAL EDUCATION. SUCH ACTION WOULD HAVE A NEGATIVE IMPACT ON PUBLIC HOSPITALS, AND HISTORICALLY BLACK COLLEGES AND UNIVERSITIES BECAUSE IT WOULD BE DIFFICULT TO TRAIN RESIDENTS. IN ADDITION, THE OVERALL FEES FOR PHYSICIANS WOULD BE DECREASED.

ADDITIONALLY, WE ARE PLEASED TO SHARE WITH YOU NMA'S POSITION ON OTHER AREAS OF THE HEALTH SECURITY ACT AND OFFER THE FOLLOWING OBSERVATIONS:

1. NMA APPLAUDS THE PRESIDENT'S COMMITMENT TO UNIVERSAL COVERAGE. WE ALSO STRONGLY SUPPORT MAKING HEALTH CARE COVERAGE AVAILABLE WITHOUT CONSIDERATION OF PRE-EXISTING HEALTH CONDITIONS.

2. WE ARE PLEASED THAT AFDC/SSI RECIPIENTS WILL NOT LOSE ANY CURRENTLY MANDATED BENEFITS AND THAT SPECIAL PROVISIONS ARE MADE FOR THE PROVISION OF ALL MEDICALLY NECESSARY ITEMS AND SERVICES FOR CHILDREN NOT INCLUDED IN THE COMPREHENSIVE BENEFIT PACKAGE. WE ARE EQUALLY PLEASED THAT NO PREMIUMS ARE REQUIRED FOR AFDC/SSI FAMILIES.

3. THE NMA APPLAUDS THE AVAILABILITY OF GRANTS AND CONTRACTS FOR THOSE SERVING THE MOST NEEDY AND MEDICALLY UNDERSERVED. WE ARE CONCERNED ABOUT THE FIVE YEAR LIMITATION ON PARTICIPATION BY ESSENTIAL COMMUNITY PROVIDERS AND URGE THAT IT BE STRICKEN IN LIGHT OF THE IMPORTANT ROLE THIS GROUP WOULD PLAY IN SERVING MEDICARE AND MEDICAID AND LOW INCOME RECIPIENTS.

4. WE ARE CONCERNED THAT AFDC/SSI FAMILIES ARE EXPECTED TO PAY 20 PERCENT OF ALL AMOUNTS LISTED IN THE CO-PAYMENT SCHEDULE. CURRENTLY ALL SERVICES ARE RECEIVED BY THESE FAMILIES WITH NO PAYMENT AT THE POINT OF SERVICE. PROVISIONS MUST BE MADE TO PHASE IN THIS REQUIREMENT AND IN CASES WHERE A CO-PAYMENT WOULD PREVENT THE PROVISION OF NECESSARY CARE, THE PAYMENT PROVISION SHOULD BE ELIMINATED.

5. WE ARE CONCERNED THAT LOW COST/HIGH COST SHARING SCHEDULES ACTUALLY TRANSLATE INTO A TWO TIER SYSTEM. AS WITH OUR CURRENT SYSTEM, THOSE WITH THE ABILITY TO PAY WILL RECEIVE THE GREATER CARE. WHEN LARGE NUMBERS OF INDIGENT PATIENTS, WHOSE HEALTH STATUS IS THE POOREST, ARE FUNNELED INTO THE LOW COST SHARING PLAN, SYSTEM OVERLOAD AND DECLINING QUALITY OF CARE WILL RESULT.

6. WE ARE CONCERNED THAT DECISIONS MADE ABOUT INCOME VERIFICATION AND PREMIUM DISCOUNTS WILL BE MADE BY THE REGIONAL ALLIANCE. YET, THERE ARE NO PROVISIONS FOR PROPORTIONAL REPRESENTATION OF ETHNIC MINORITIES OR THE REPRESENTATION OF CONSUMERS (PARTICULARLY LOW INCOME CONSUMERS) AT THAT LEVEL.

NMA OPPOSES THE LIMITATION ON MEMBERSHIP OF THE BOARD OF DIRECTORS OF REGIONAL ALLIANCES, WHICH AS CURRENTLY WRITTEN WOULD BE COMPOSED OF EMPLOYERS WHOSE EMPLOYEES PURCHASE HEALTH COVERAGE THROUGH THE ALLIANCE AND MEMBERS WHO REPRESENT INDIVIDUALS WHO PURCHASE SUCH COVERAGE. HEALTH CARE PROVIDERS, WHO ARE IN THE BEST POSITION TO ADVOCATE FOR THE HEALTH NEEDS OF MEDICAID AND MEDICARE RECIPIENTS, ARE SPECIFICALLY PREVENTED FROM PARTICIPATING ON THESE BOARDS.

7. WE ARE CONCERNED ABOUT FINANCING AND STRONGLY OPPOSE ANY SPENDING REDUCTIONS IN MEDICARE. MEDICARE FUNDS MUST NOT BE USED TO FINANCE HEALTH CARE REFORM, INSTEAD THE PROGRAM MUST BE RESTRUCTURED AS TO PROVIDE ADEQUATE COVERAGE FOR THESE RECIPIENTS. NMA HAS ENDORSED TAXES ON ALCOHOL AND FIREARMS AS FAIR AND APPROPRIATE REVENUE SOURCES.

8. WE ARE CONCERNED THAT THE SLIDING SCALE FOR ADJUSTMENT OF PREMIUM DISCOUNTS, APPLIES TO FAMILY ADJUSTED INCOME ABOVE 150 PERCENT OF THE POVERTY LEVEL. IN FACT, THERE IS A GRADUATED PHASE OUT OF THE DISCOUNT UP TO 150 PERCENT OF THE POVERTY LEVEL. THIS IS A VERY LOW THRESHOLD.

9. WE ARE CONCERNED THAT PROVISIONS ARE NOT MADE FOR A MECHANISM FOR ADULTS (CHILDREN ARE COVERED) WHEREBY UNCOVERED, MEDICALLY NECESSARY BENEFITS MAY BE GRANTED.

10. WE ARE CONCERNED THAT CONVENIENT HOSPITAL AND HEALTH PROFESSIONALS ARE CURRENTLY NOT AUTOMATICALLY CERTIFIED AS ESSENTIAL COMMUNITY PROVIDERS. PUBLIC HOSPITALS AND CLINICS ARE THE ESSENTIAL COMMUNITY PROVIDERS FOR MEDICARE RECIPIENTS RIGHT NOW.

11. NMA URGES THE PROVISION OF GRANTS TO STATES FOR EDUCATIONAL SERVICES WHICH ARE CULTURALLY SENSITIVE AND CULTURALLY COMPETENT. ORGANIZATIONS WHICH ARE MULTI-DISCIPLINARY AND COMMUNITY-BASED SHOULD BE CHARGED WITH EDUCATING THE NEWLY INSURED ON ACCESSING THE HEALTH CARE DELIVERY SYSTEM.

THE NMA RECOGNIZES THE NECESSITY TO GAIN CONTROL OF THE HEALTH CARE CRISIS IN THIS COUNTRY. WHILE REVAMPING THE MEDICARE PROGRAMS, ONE WHICH PAYS FOR MEDICAL CARE FOR MANY OF THE NATION'S ELDERLY, DISABLED AND POOR, WE MUST REMAIN COGNIZANT OF THE ACCOMPLISHMENTS OF THIS PROGRAM IN PROVIDING ACCESS TO MEDICAL CARE FOR THE POOR. AVAILABLE EVIDENCE SUGGESTS THAT MEDICARE HAS BEEN FAR MORE VALUABLE THAN IS COMMONLY REALIZED. IT HAS SERVED A BROAD CROSS-SECTION OF THE AMERICAN PEOPLE AND ITS ADOPTION COINCIDES WITH SIGNIFICANT IMPROVEMENTS IN THE HEALTH STATUS OF AMERICANS. NOT WIDELY RECOGNIZED IS THE PROGRAM'S IMPORTANT TO THE FINANCIAL WELL-BEING OF NOT THE VERY SURVIVAL OF MANY MAJOR TEACHING HOSPITALS AND THE MAJORITY OF NURSING HOMES IN THIS COUNTRY.

MR. CHAIRMAN, MEMBERS OF THE COMMITTEE, THE NMA IS COMMITTED TO WORK WITH GOVERNMENT DECISION-MAKERS, AND LEADERS OF PRIVATE AND PROFESSIONAL ORGANIZATIONS IN FORMULATING HEALTH CARE POLICY WHICH MUST BENEFIT MEDICAID AND MEDICARE RECIPIENTS AND PERSONS OF LOW INCOME.

THANK YOU FOR ALLOWING THE NMA TO HELP ENSURE THAT THE SPECIAL NEEDS OF UNSERVED, UNDERSERVED, AND UNDERREPRESENTED MEMBERS OF OUR POPULATION ARE ADDRESSED BY HEALTH REFORM INITIATIVES. WE WELCOME THE OPPORTUNITY TO CONTINUE TO WORK WITH YOU AND MEMBERS OF THIS COMMITTEE.

Chairman STARK. Dr. Jacott, I have listened to your testimony and sort of reviewed the complete testimony, and while I am sympathetic to many of your complaints and concerns, I have yet to be able to determine what the AMA would suggest to this committee or to the President as to how we can control the rate of increase of physician fees either individually or in the aggregate.

Now, I want to eliminate from that what other people can do like patients who buy too much or greedy lawyers, the AMA has blamed a lot of this on everybody else, they blamed it on the patients and on the lawyers. Now, how do we control what we pay the docs, how would you suggest is the best or the least objectionable? Do we control the fees universally as we do under Medicare? Do we capitate all of you? Do we put a gross income limit on what each doctor can earn? How do we do it?

Dr. JACOTT. One of the areas that we have suggested and we have spent a great deal of time on is trying to get some antitrust relief.

Chairman STARK. No, no, now you are blaming the Justice Department. I am just saying you as an individual. You have talked, I won't accuse you of this, I won't turn you over to the Justice Department, but you have talked about this in the locker room or either at the hospital, the golf course or in your classes. How would you say that we apply any kind of financial payment restrictions or regulations on doctors' fees or salaries for those who work for salary in order to control the rate of increase on those fees?

Again, I don't know of any alternatives outside of setting fees, setting aggregate earnings, capping physicians. I mean, if you know—and as I say when you hop to the Justice Department, that is a structural issue which is—how do we control individual physician income which, after all, added up is the aggregate in costs to the American economy? What is the least objectionable way to do that?

Dr. JACOTT. I think one attempt to do that has been the RBRVS, which is a system that actually looks at work done and sets payment based on relative values. You are very familiar with that.

Chairman STARK. I am, indeed.

Dr. JACOTT. We support that. We think that is a good system.

Chairman STARK. So you think that is better than just suggesting that we tax your growth in earned income or that we push everybody through a variety of structures into a salaried or capitated situation that we could work with the resource-based relative value scale, and then we could confine our negotiations and arguments to the conversion factors, and the fine-tuning of the resource-based issue, which arguably is something that you would do inside the medical community and not done here; of all the alternatives that you personally are aware of, that is about as good as anything we have to deal with?

Dr. JACOTT. Yes, I think that is a good alternative, and then to move that beyond Medicare so that that system is used fairly by all payers.

Chairman STARK. Well, it is happening a bit at a time without legislation, I understand. OK.

Well, can you live with that, Dr. Walton?

Dr. WALTON. That is correct, it works very well under that system. As long as we have it done universally, it works well.

Chairman STARK. Mr. Lewis, you have got to donate something to this now. You argue that Medicare beneficiaries should be enrolled in managed care plans because—and I think I am quoting you accurately—“patients have a financial incentive to purchase coverage from cost-effective providers.”

I would challenge you that most patients, when they get to the situation of being sent to the hospital, don't have the foggiest idea what it costs to go to the hospital, but assume you are right, then as a CEO how would your hospital care for a Medicare patient more efficiently if they were enrolled in a managed care plan than they would if Dr. Jacott sent them in and they were a Blue Cross beneficiary? Would you provide the managed care beneficiary fewer tests or less nursing attention? Put them in a ward in the old part of the building where they didn't have built-in television? What would you do in your hospital to save money on the managed care beneficiaries as opposed to those who have an indemnity plan?

Mr. LEWIS. Mr. Stark, I think what we are talking about is going from one end of the spectrum, which is a straight fee-for-service kind of situation, to a managed plan.

Chairman STARK. I am just talking about hospitals.

Mr. LEWIS. Right. But when we talk about this, I think we have to be talking about everybody having consistent incentives. Right now that is not the case in general. Even with the managed care contract that the hospital may have, the physicians are still paid on a fee-for-service basis beyond the primary care.

Chairman STARK. Not always. Some are paid on a salary.

Mr. LEWIS. Some are paid on a salary, but many—in fact most—

Chairman STARK. Do you have any physicians on salary at your hospital? Are you allowed to do that?

Mr. LEWIS. Yes, we are a medical school hospital and we do have some physicians on salary.

What I was saying earlier is we need to somehow bring the incentives for the hospital and the physician more closely in line so that one is not driven on volume and the other driven on reducing volume.

Chairman STARK. Do you think that if I were to go and have a procedure, have my gallbladder removed, who do you think should be in charge of that and bargain for me, the doctor or the hospital?

Mr. LEWIS. Have what, I am sorry?

Chairman STARK. Have my gallbladder removed.

Mr. LEWIS. The doctor should be in charge of you.

Chairman STARK. What if we let the doctor, just say here, Doc, I have \$3,000 worth of insurance, you pick the hospital and tell the hospital what to do, then you hire the anesthesiologist and the radiologist and the pathologist and whatever else, I don't know what they do, and you keep me in the hospital as long as you think I should be there, and then you get whatever is left over. Would that be a good way to run the system?

Mr. LEWIS. It would be an interesting approach, and I think there are—

Chairman STARK. That is how it used to run when I was a kid.

Mr. LEWIS. There are some operations around the country that I think operate that way. I can't tell you how well they function. I think there is an opportunity for a system to receive a payment to take care of a patient from the beginning to end, and then effectively distribute the income from that.

Chairman STARK. You still haven't told me how you are going to save me some money, how you differentiate. As I say, you seem to think that patients in a managed care plan have a financial incentive to purchase from cost-effective providers, and I am a little at sea here as to how that works. Do you just change the price or do you actually change the type of care you provide for—let's say you got three different patients who come in on the same day, each for the same procedure, some procedure that your hospital does frequently. One has got Blue Cross indemnity. What managed care do you guys deal with, Aetna?

Mr. LEWIS. We deal with Blue Cross, we deal with U.S. Health Care.

Chairman STARK. OK. Any big insurance companies other than Blue Cross—

Mr. LEWIS. A number of different ones.

Chairman STARK. How do you differentiate the care you give those patients, depending on what plan they are in?

Mr. LEWIS. We are not talking about providing a different level of care for different patients.

Chairman STARK. But you provide different fees to those different plans, don't you?

Mr. LEWIS. Right.

Chairman STARK. Why?

Mr. LEWIS. Excuse me?

Chairman STARK. Why should you charge Blue Cross a different rate than you charge any of the other health plans for the same care, for the same procedure?

Mr. LEWIS. We basically negotiate rates with each of the plans, based on the activity that will come about.

Chairman STARK. Give me an economic reason for that. What sense does that make to the economy as a whole? Somebody is getting stuck, right?

Mr. LEWIS. That goes back to the cost-shifting.

Chairman STARK. I am just talking among the private plans, Blue Cross, Pru, and this other one you mentioned, why should one of them get more or less of a bargain from you than the other? Is there an economic reason for that?

Mr. LEWIS. Basically, those relationships are based on the volume of activity that comes to the institution from those plans.

Chairman STARK. Why shouldn't you have to give the same volume discount, why shouldn't you just base that on the volume of your hospital at the end of the year—a good year, you give everybody a rebate, just sort of like the credit union?

Mr. LEWIS. I don't have an answer for that question.

Chairman STARK. They do that in Maryland, you know.

Mr. LEWIS. I do know that, yes.

Chairman STARK. It works pretty well, and I would suggest that maybe a system like that—I wish Mr. Cardin were here to explain

to you how it works. They are very pleased with it. It is a fairly structured system.

I would suggest to you that you are dealing with patients who, I think, don't have the foggiest idea of how to enter into this system, the medical delivery system; and that, in fact, we might have you guys who are pros dealing with other people who are pros, like some kind of a board who have the expertise and the knowledge that you have, and get you a fair price so you can adjust it on a variety of issues. Somehow, I am much more comfortable.

I guess what I am trying to push you away from here is this competition idea, which may exist between you and a neighboring hospital, but not between those three people who come in to get their gallbladder removed. They don't know from one end to the other why you are different from the hospital across the street, and so I would just try to dissuade you a little bit from what good it would do us to have that kind of competition.

Dr. Walton, you bring to mind a problem dear to my heart. I don't think the Medicare cuts are going to hurt you at all because I think there is so precious little money spent in Ward 7 and Ward 8 now that I don't know what the hell you would notice if we cut it in half. I heard something to the effect that we have maybe 100,000 people in Ward 7 or Ward 8 who are either uninsured or Medicaid eligible, but yet have not qualified for Medicaid. Would that be a reasonable number?

Dr. WALTON. That is correct, and that is a very reasonable number, Mr. Chairman.

Chairman STARK. We have one plan down there that takes care of 16,000 people, something like a total of nine primary care docs to deal with 16,000 people, I think eleven—seven of which are pediatricians and four of which are basically GPs. Is that an adequate ratio?

Dr. WALTON. That is an adequate ratio. In fact, you know, we are a congressionally mandated, underserved urban area.

Chairman STARK. You don't think that is enough doctors to deal with 16,000 people, do you?

Dr. WALTON. No, sir.

Chairman STARK. How do you feel when somebody like the Prudential Insurance Company comes in and testifies that they won't bid to serve the District of Columbia because our laws in the District of Columbia require that anybody serving this area make all of their providers available to all of their beneficiaries, and Prudential testified that they have many providers who would not choose to provide care to Medicaid beneficiaries, and therefore Prudential wasn't going to bid on service in the District of Columbia.

That doesn't sound like a very brotherly approach to providing medical care, does it?

Dr. WALTON. No, it doesn't; but that is a fact of life, and this is why we are very much concerned about this two- or three-tiered system of health care that we are currently undergoing right now. We see it on a daily basis.

Chairman STARK. I will bet you are almost as old as I am and remember the debit man?

Dr. WALTON. Yes.

Chairman STARK. Did your mother put money in the sugar bowl to pay the debit man who came by on Friday? You used to trust those guys, didn't you?

Dr. WALTON. That is right.

Chairman STARK. You heard about their selling investments recently, and paying their salesmen fees when they weren't licensed to get them. Now they have like \$30 million that they have to pay back.

Do you feel comfortable about the new era debit man helping your mother get her medical care today?

Dr. WALTON. No, I certainly don't. It is very real.

Chairman STARK. The good old days in some of those cases weren't so bad, were they?

We have had some people here today who share my concern about the underserved areas, as you suggest, and I do commend Howard and the District government, as best as they are able with the kind of geographic problems we have here in the District; and I appreciate your work. I hope that we can—by providing coverage, we still must provide access, and I think you and I know that in many cases we have people—we have far more than 16,000 people who have Medicaid coverage in ward 7 and ward 8.

Dr. WALTON. Far more than that; you are absolutely correct.

Chairman STARK. But they don't always have access, do they, to primary care?

Dr. WALTON. They don't have access.

Chairman STARK. And those things can't be separated.

I hope we can find a way to—and I think we are well on our way, by the way. The physicians have, and all of their organizations—we will hear from some more in a minute—been most helpful, and I know that the hospitals are concerned about what would happen.

One question, Mr. Lewis, what do you think about the mandatory State alliances? Do the hospitals like that idea?

Mr. LEWIS. We are a little concerned with the size that those organizations might become. This plan, it seems to us, depends on a lot of things working out very quickly.

Chairman STARK. What State are you from? Missouri?

Mr. LEWIS. Pennsylvania. My biggest fear certainly is that we will move ahead very quickly on identifying cost reduction opportunities in terms of the Medicare and Medicaid budgets, and at the same time not move along on the other side of identifying opportunities for savings within the system, not just driven by the hospitals but driven by the way that—the system that the hospitals work in. Obviously, that is a concern.

Chairman STARK. It is, and I guess I would like to keep it a whole lot simpler.

I will ask you one more question. I have made the statement often that precious few hospitals in the country would fail if they received the Medicare payment rate for every patient who came through the door and it were, in fact, the single-payer system. So your bookkeeping department would virtually disappear, or be cut in half at least; and you would be getting, I suppose, whatever you consider your rate, 93 percent, if that is about a national average. But no more charity, no more disproportion, no more bad debt, pay-

ment within 30 days—or interest if we don't—could you survive on that?

Mr. LEWIS. I think that if we had some commitments along the lines of increasing those numbers appropriately with inflation, with growth in technology, with growth in the population, that certainly I believe that most—not most, but at least we could survive that.

Chairman STARK. It wouldn't be fun?

Mr. LEWIS. No, it would not be fun, but we are all working very hard to do a couple of things, and one of them is to contain our costs more in light of our local environment in the price competition, but certainly in anticipation of what may come down the road; and we would have to work significantly harder at that, obviously, under the scenario you just painted.

Chairman STARK. I want to thank the panel very much. You have been most helpful. We appreciate it very much.

Dr. JACOTT. Thank you.

Dr. WALTON. Thank you very much.

Mr. LEWIS. Thank you.

Chairman STARK. Our fourth panel includes four witnesses representing physician groups. I would welcome Dr. Stephen Evans, who is assistant professor of surgery at Georgetown University Medical Center, on behalf of the American College of Surgeons; Dr. Howard Shapiro, who is director of public policy for the American College of Physicians; Dr. K.K. Wallace, who is chairman of the American College of Radiology; and Dr. Gordon McLean, who is president of the society for Cardiovascular and Interventional Radiology.

I really don't know what that is, but welcome to the subcommittee, gentlemen. Why don't you proceed to summarize in the order in which I called your names?

Dr. Evans, do you want to lead off.

**STATEMENT OF STEPHEN R.T. EVANS, M.D., FELLOW,
AMERICAN COLLEGE OF SURGEONS, AND ASSISTANT PRO-
FESSOR OF SURGERY, GEORGETOWN UNIVERSITY MEDICAL
CENTER**

Dr. EVANS. Mr. Chairman and Members of the subcommittee, I am Stephen Evans, fellow of the American College of Surgeons, and assistant professor of surgery at Georgetown University Medical Center. On behalf of the more than 60,000 fellows of the American College of Surgeons, I am pleased to share our views about the President's proposals to help finance health care reform through major new reductions in payments for services under the Medicare program.

The College recognizes that health reform will undoubtedly require an additional financial commitment, the scale of which is not yet clear, to achieve the goal of universal access, but the College believes that the administration has unrealistic expectations about how much of this financial support should come from very deep reductions in current payments for services provided to the elderly and disabled under the Medicare program. We do not see how it is possible to adopt cuts of the magnitude proposed in the draft Health Security Act without potentially undermining beneficiary and provider confidence in the integrity of the Medicare program.

In general, Medicare is a program that works. It still assures most older Americans that they can obtain the high-quality health care services they need in the communities in which they live from the physicians and hospitals of their choice. Adopting further massive reductions in payments for Medicare services, even before we know the extent of the commitment to or shape of a health reform plan that Congress may approve, seems an unwarranted step to take at this time.

The magnitude of the Medicare cuts proposed in the President's health reform plan is not the College's only concern. While we do not, in general, disagree with the primary care policy objectives raised in the plan, we are very disturbed by the apparent attempt to address many of these objectives at the expense of other physician services that the elderly also require.

For example, it can hardly be considered fair for the administration to propose paying surgical services less than justified under Medicare's resource-based payment methodology in order to pay primary care services more than is justified under the same resource-based approach. We thought this subcommittee and Congress had approved the resource-based fee schedule in an effort to establish payment amounts that accurately reflect the work resources involved in providing physician services, adjusted by performance-based volume considerations. However, the President's budget plan for Medicare makes a sham out of this so-called resource-based system.

Similarly, we think it is inequitable, even rather odd, for the President to recommend eliminating the 10 percent payment incentive for the provision of surgical and most other services in urban health profession shortage areas as a way of doubling the payment bonus for primary care services that are provided in rural and urban shortage areas.

The College does not take issue with the interests of policy-makers to meet more effectively the primary care needs of all Americans, including Medicare patients. However, some elements of the President's program seek to achieve this goal in ways that are unfair and can potentially pose barriers to assuring the continued availability of all physician services, not just primary care services alone.

The President's Medicare budget reduction plan includes a number of proposals that would directly affect payment for physician services under the Medicare fee schedule. The first of these would establish cumulative expenditure goals for physician services under the Medicare volume performance standard, the MVPS system well known to you. If we understand this provision correctly, fee schedule default updates, beginning in 1996 and thereafter, would be increased or decreased, taking into account changes in actual expenditures due to changes in the volume and intensity of services over a cumulative period of time.

A second but related provision would prescribe using growth in the gross domestic product as the proxy for estimating expected changes in the volume and intensity of physician services to set MVPS targets.

We are concerned about adopting such major changes in the MVPS system so soon after we have only just begun to develop

some actual experience with its effects on spending growth due to volume changes. Constant changes in the design of the MVPS concept can only make it more and more difficult to understand the incentives for which it was adopted.

As you know, Mr. Chairman, the College has been and remains a major supporter of the performance-based expenditure target concept. We have been gratified by the support we have received from you and the other Members of this subcommittee in creating a separate MVPS for surgery; and we have been pleased to see that this standard has been met in each of the last 2 years.

We believe that the present methods for setting the targets and measuring performance have made understanding of these incentives under the MVPS very clear. We are concerned that a cumulative approach for comparing targets with performance, as the President proposes, does not make the potential risks or rewards as clear as they are under the current system.

The use of the GDP index is the formula proxy to adjust for volume and intensity to set the MVPS targets—except for primary care, where preferential treatment is given—means that Medicare would essentially disregard the actual trends in the demand for most physician services and the impact of expanded use of new technologies to care for patients covered by the program. Instead, growth in the economy alone would become the standard for determining how much should be spent for physician services in tomorrow's Medicare program. If adopted, this provision further underscores a shift in Medicare spending policy from finding ways to pay for the care our older citizens actually need to financing their care on the basis of what the economy can afford.

Another provision in the President's bill calls for a 3 percent reduction in the Medicare fee schedule conversion factor in 1995 for all services but primary care. Make no mistake, this is not a 3 percent cut in the rate of growth. Rather, it is a 3 percent reduction that will be imposed after freezing the 1994 conversion factors applicable to most physician services under the fee schedule, including surgical services.

Moreover, because the conversion factor would not be adjusted before the reductions are made, the proposal completely ignores the performance-based principles used to set the MVPS targets for 1993. This proposal also seems to ask of some physicians what is not being asked of others. We regard this provision as unfair and hardly in keeping with the President's call in the past for shared sacrifice in an effort to address Medicare's budget and spending problems.

The President's plan to finance health care reform through Medicare cuts would establish an entirely new control program of limitations on payment for physician services furnished by high-cost medical staffs. We strongly oppose this plan, which can particularly penalize physicians who serve on the medical staffs of those hospitals that today meet the needs of Medicare patients having especially complex problems that require the most intensive kinds of surgical and other physician services. If the Medicare fee schedule is resource-based, and if physicians ought to be paid for their services they provide, then this provision is entirely unjustified and serves no policy objective whatsoever.

The plan would also punish physicians on the staffs of rural hospitals by paying the medical staffs of some institutions no more than an arbitrarily determined amount compared with services provided to Medicare patients in other rural hospitals. It could even encourage physicians to transfer their patients from one hospital to another in order to escape the effects of this unwarranted penalty.

Medicare patients—all patients for that matter—should be entitled to receive the surgical and physician services that are medically indicated and necessary, and the physicians who provide the services ought to be fairly compensated for providing that care, based on the work they perform. The administration's proposal is inconsistent with these goals and ought to be rejected in its entirety.

Finally, Mr. Chairman, as I said at the outset, we oppose those provisions in the President's plan that arbitrarily increase payments under Medicare for primary care services by just as arbitrarily reducing payments for all other physician services. Either Medicare pays for physician services on the basis of the work performed, as Congress determined when it adopted physician payment reforms, or it does not. Millions of dollars and several years were spent in designing a fee schedule that was supposed to achieve this objective. However, our members, when they study the administration's proposals, are hard-pressed to understand how this exercise has ever served any objective in recent years except that of budget reduction alone.

These so-called "incentives" for physicians to provide primary care would be achieved only at the expense of other physicians and ought not for this reason to be accepted in the form in which you are being asked to consider them.

Once again, the College appreciates the opportunity to share its views on these issues, and I would be pleased to answer any questions you may have at the end.

Chairman STARK. Thank you.

[The prepared statement follows:]

STATEMENT
of the
AMERICAN COLLEGE OF SURGEONS

to the
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives

presented by

Stephen R.T. Evans, MD, FACS

RE: Medicare and Health Care Reform

November 23, 1993

Mr. Chairman and Members of the Subcommittee, I am Stephen R.T. Evans, MD, FACS, Assistant Professor of Surgery at Georgetown University Medical Center. On behalf of the more than 60,000 Fellows of the American College of Surgeons, I am pleased to share our views about the President's proposals to help finance health care reform through major new reductions in payments for services under the Medicare program.

The College recognizes that health reform will undoubtedly require an additional financial commitment--the scale of which is not yet clear--to achieve the goal of universal access. But, the College believes that the Administration has unrealistic expectations about how much of this financial support should come from very deep reductions in current payments for services provided to the elderly and disabled under the Medicare program. We do not see how it is possible to adopt cuts of the magnitude proposed in the draft Health Security Act without potentially undermining beneficiary and provider confidence in the integrity of the Medicare program.

In general, Medicare is a program that works. It still assures most older Americans that they can obtain the high quality health care services they need in the communities in which they live from the physicians and hospitals of their choice. Adopting further massive reductions in payments for Medicare services--even before we know the extent of the commitment to, or shape of, a health reform plan that Congress may approve--seems an unwarranted step to take at this time.

The magnitude of the Medicare cuts proposed in the President's health reform plan is not the College's only concern. While we do not, in general, disagree with the primary care policy objectives raised in the plan, we are very disturbed by the apparent attempt to address many of these objectives at the expense of other physician services that the elderly also require. For example, it can hardly be considered fair for the Administration to propose paying surgical services less than justified under Medicare's resource-based payment methodology in order to pay primary care services more than is justified under the same resource-based approach. We thought this subcommittee and Congress had approved the resource-based fee schedule in an effort to establish payment amounts that accurately reflect the work resources involved in providing physicians' services, adjusted by performance-based volume considerations. However, the President's budget plan for Medicare makes a sham out of this so-called resource-based system.

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eliminating the 10 percent payment incentive for the provision of surgical and other most services in urban health professions shortage areas as a way of doubling the payment bonus for primary care services that are provided in rural and urban shortage areas.

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We are concerned about adopting such major changes in the MVPS system so soon after we have only just begun to develop some actual experience with its effects on spending growth due to volume changes. Constant changes in the design of the MVPS concept can only make it more and more difficult to understand the incentives for which it was adopted. As you know, Mr. Chairman, the College has been and remains a major supporter of performance-based expenditure target concepts. We have been gratified by the support we have received from you and the other members of this subcommittee in creating a separate MVPS for surgery, and we have been pleased to see that this standard has been met in each of the last two years. We believe that the present methods for setting the targets and measuring performance have made understanding of the incentives under the MVPS very clear. We are concerned that a cumulative approach for comparing targets with performance, as the President proposes, does not make the potential risks or rewards as clear as they are under the current system.

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The President's plan to finance health reform through Medicare cuts would establish an entirely new control program of limitations on payment for physicians' services furnished by high-cost medical staffs. We strongly oppose this plan, which could particularly penalize

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Medicare patients--all patients for that matter--should be entitled to receive the surgical and physician services that are medically indicated and necessary. And, the physicians who provide these services ought to be fairly compensated for providing that care based on the work they perform. This Administration proposal is inconsistent with these goals, and ought to be rejected in its entirety.

Finally, Mr. Chairman, as I said at the outset, we oppose those provisions in the President's plan that arbitrarily increase payments under Medicare for primary care services by just as arbitrarily reducing payments for all other physicians' services. Either Medicare pays for physician services on the basis of the work performed, as Congress determined when it adopted physician payment reforms, or it does not. Millions of dollars and several years were spent in designing a fee schedule that was supposed to have achieved this objective. However, our members, when they study the Administration's proposals, are hard-pressed to understand how this exercise has ever served any objective in recent years except that of budget reduction alone. These so-called "incentives" for physicians to provide primary care would be achieved only at the expense of other physicians and ought not, for this reason, be accepted in the form in which you are being asked to consider them.

Once again, the College appreciates the opportunity to share its views on these issues, and I would be pleased to answer any questions you may have.

Chairman STARK. Dr. Wallace.

**STATEMENT OF K.K. WALLACE, M.D., CHAIRMAN, BOARD OF
CHANCELLORS, AMERICAN COLLEGE OF RADIOLOGY**

Dr. WALLACE. Thank you, Mr. Chairman. My name is K.K. Wallace. I am a radiologist at the University of Virginia in Charlottesville. I serve as chairman of the American College of Radiology board of chancellors.

Before I address our concerns about the President's health care system revision proposal, I would like to thank you, Mr. Chairman, on behalf of the entire radiology community for your tenacity and success on legislation on self-referral and joint ventures contained in the budget bill.

The American College of Radiology supports efforts to improve our health care delivery system, but we urge the subcommittee to fix only what is broken. We have been before this subcommittee many times, and we have outlined some of the faults in the system as they pertain to providing diagnostic and therapeutic radiology services to patients.

We have worked with the Congress and previous administrations to assure that patients have access to the best radiology service, provided by the most qualified individuals at a reasonable price. Our goals have not changed.

Unfortunately, the President has recommended changes in Medicare that go too far. The recommended changes are intended to shift money from Medicare to attempt to accomplish other things in revision of the health care system and are not intended to remedy problems in Medicare. We urge your rejection of these changes.

Our greatest concern involves the President's offering a RAPs or bundling of physician services proposal for Medicare. Granted, it is presented in a different way, thinly veiled as a competitive bidding mechanism for computerized tomography, CT, and magnetic resonance or MRI scans, but it is a RAPs in proposal nevertheless; and we urge the subcommittee to reject this for the fifth time.

Mr. Chairman, when this came up in 1987, you challenged us to work with the Congress, and we did indeed work with this subcommittee, with the Congress, with the administration, and with our members, and we measured up to the challenge. The competitive bidding proposal would jeopardize availability and quality of these services—that is, MRI and CT, and has a large, unfortunate potential for inconvenience to patients and referring physicians.

For example, I can envision nightmares in trying to coordinate a study done in my institution with an MRI scan done on the same patient in a different location.

This proposal would also create a mechanism to oversee quality, which would require substantial Federal resources. This would negate illusory projected savings. Currently, the quality of these services is measured every day through peer review by referring physicians. This contracting scheme would eliminate this effective quality assurance mechanism.

While the President has yet to publish a justification for this recommendation, we assume it is based on some assumption that utilization of radiology services is inappropriate. We are also concerned about inappropriate use of radiology procedures, but this

proposal is shortsighted and should be rejected. The best way to address the consideration or appropriate utilization of radiology services is with patient care guidelines.

The American College of Radiology is in the process of developing such guidelines that can be used along with valid accreditation programs to assure that patients are receiving the best and most appropriate care. These guidelines can identify which procedures are most beneficial and also identify those which are cost-effective.

Another element of concern regarding inappropriate use of radiology services is over self-referral of these services by nonradiologists. This self-referral goes beyond that addressed in the joint venture legislation.

The President has also recommended substantial changes in the Medicare fee schedule and how certain physicians are paid. We oppose further changes in the fee schedule until it is fully implemented and there has been ample opportunity to see how it works.

We are also in opposition to the proposal which would single out groups of physicians such as hospital medical staffs for mechanisms which appear to us to be nothing more than complicated volume performance standards.

Finally, we are concerned about recommendations to dramatically alter the mix of specialists through changes in the way Medicare pays for graduate medical education and other means. We do not believe that there is sufficient data on the projected need for physicians in different specialties to make such drastic changes in this essential element of our health care system.

Thank you for this opportunity to present our views. We look forward to working with the Congress as this proceeds.

[The prepared statement follows:]

**TESTIMONY OF K.K. WALLACE
AMERICAN COLLEGE OF RADIOLOGY**

The American College of Radiology is pleased to present the following testimony addressing issues in health care system reform that pertain to the Medicare program.

The ACR supports efforts to improve our health care delivery system. Unfortunately, many of the President's recommendations for change to our current system will not improve the care that Medicare patients receive and would jeopardize access to needed medical care. We urge that the subcommittee fix only what's broken and not disrupt what is recognized as the best health care system in the world.

The Administration's Health Security legislation contains recommendations for further significant reductions in federal spending for Medicare. The ACR is concerned that these reduction proposals, intended only to provide funding for expanded benefits elsewhere in the health system, are too great. They are not intended to address problems in the Medicare payment system.

We and many others in medicine and the government have worked with this subcommittee and the Congress for several years to reform physician payment under Medicare. Let us give it a chance. The ACR opposes further changes in the Medicare fee schedule until it is fully implemented and there has been ample opportunity to see if it works. Major changes and funding reductions before this refinement is complete is short-sighted.

We are opposed to differential updates for different groups of physicians. The purpose of the RBRVS fee schedule was to correct perceived inequities in payments among physicians. Having implemented that system after substantial study and debate it is inappropriate to make arbitrary changes in payments.

The President has proposed that medical services including magnetic resonance imaging and computerized axial tomography be provided under a competitive bidding mechanism. The proposal would require that contracts for these services include not only the technical costs of providing the service, but the physician's professional service to the patient as well. We believe this is a thinly veiled effort to bundle hospital and physician services and should be rejected by the subcommittee for the fifth time.

It is inappropriate to jeopardize the availability and the quality of these services with this mechanism. It is also inappropriate to create a mechanism with a great potential to inconvenience patients and referring physicians with no definable cost benefits.

No current mechanism exists to assure that such a system would assure availability and quality. Creating a mechanism to assure quality would require substantial federal resources which would negate the administration's projection of savings.

The President has not published any justification for this recommendation. No evidence is offered of inappropriate utilization levels of radiology procedures. Questions of appropriate utilization of these and other radiology procedures are best addressed with patient care guidelines.

It is also inappropriate to include physicians' services in this proposed mechanism. Currently, the quality of the radiologist interpreting these studies is measured on a daily basis through peer review by referring physicians. Contracting eliminates this effective mechanism. Jeopardizing services such as CT and MRI which have provided substantial improvement in the diagnosis of patients is short-sighted and should be rejected.

The ACR is concerned about the inappropriate utilization of radiology services. A part of our concern is over the self-referral of these services by non-radiologists. We believe that through the use of standards, guidelines and accreditation programs patients can be assured of receiving the best and most appropriate service.

We are pleased that the 1994 budget addressed an important facet of the self-referral problem with a provision which would bar physician referrals to outside facilities in which they have ownership interest. For almost a decade, the ACR has raised this issue and we are pleased that recognition of this

problem has now garnered almost universal acceptance. But, this is only a part of the problem.

Based on Medicare data and peer-reviewed studies, we find that joint venture self-referral is only a small portion of the self-referral problem. The growth of self-referral done directly by non-radiologists has been substantial. We believe that medicine and the Congress can address this utilization problem which would result in significant savings while ensuring the most appropriate care.

Where there is inappropriate utilization beyond self-referral, we stand ready to define a system to eliminate it. Work has begun on such a system. We believe we are uniquely positioned in the health care delivery system to develop patient care guidelines for diagnostic imaging and therapeutic radiology. Because of our consultative role in medicine, patients are seen on a referral basis and the inherent conflict of interest in self-referral is avoided.

These guidelines would identify what procedures are most beneficial to patients and also could identify which procedures are most cost-effective. We believe such guidelines would produce significant savings in the health care system with no negative impact on the quality of care given patients. We also believe that such a system would not only provide for the most appropriate care by physicians but that the care would be provided by those specifically trained to interpret such procedures. It is essential that the system of patient care guidelines be unambiguous so there can be easy compliance and monitoring.

The ACR believes these initiatives to be realistic recommendations to deal with problems of cost and over-utilization of radiology services, while at the same time assuring that patients receive the services that are appropriate.

It is essential that the development of guidelines and standards and efforts to assure the highest quality be directed by the physicians directly responsible for the services. The American College of Radiology has been active in quality assurance efforts for the practice of radiology through accreditation programs and the establishment of standards.

As an example, the ACR Mammography Accreditation Program offers radiologists the opportunity for peer review and evaluation of their facility's staff qualifications, equipment, quality control and quality assurance programs, image quality, breast radiation dose and processor quality control. The accreditation is for a three year period and yearly surveys are performed to assure the facility continues to meet the standards established for the program. Facilities not meeting the criteria are given recommendations for meeting the standards and encouraged to reapply.

The impetus for the program came as a result of the concerns of radiologists, other national medical organizations, the government, and the public that qualified personnel perform and interpret mammograms and that dedicated mammographic equipment be used to ensure that women receive optimum mammographic examinations with the lowest possible risk.

Each facility must submit an application which includes the qualifications of radiologists, radiologic physicists and radiologic technologists. The supervising and/or interpreting physician must have had two months of documented, formal training reading mammograms, with instruction in medical radiation physics, radiation effects and radiation protection, with evidence of a formal examination in these subjects. Alternatively, the physician may be certified by the American Board of Radiology or the American Osteopathic Board of Radiology.

We believe programs such as the accreditation program should be the basis of quality assurance. These programs are developed on a voluntary basis by the physicians themselves. In the case of mammography, by radiologists, who are the experts in mammography. Screening mammography was the first preventive service to be accepted by Congress and covered by Medicare.

The requirements for quality assurance of screening mammography in current federal law are equivalent to the requirements of the ACR accreditation program. We are very proud that because of our accreditation

program women across the country can have quality screening mammography.

Another most important program of the ACR has been the development of standards. In 1989, the College began developing practice standards. Our rigorous standard-setting process underscores the College's commitment to quality. To date, the College has adopted twenty-six standards. And there are new standards in the pipeline from various College committees.

These standards will help to advance the science of radiology and improve the quality of service to patients throughout the United States. The standards will be continually reviewed in an attempt to describe the best available knowledge about current radiologic technologies and new modalities.

Each standard, representing a policy statement by the College, has undergone a thorough consensus process in which it has been subjected to considerable review, requiring the approval of the ACR Board of Chancellors, the ACR Steering Committee and the ACR Council. The standards recognize that the safe and effective use of diagnostic and therapeutic radiology requires specific training, skills and techniques as described in each document.

If guidelines are to work, there must also be meaningful reform of the professional liability environment. Many states have adopted changes in the law to reform professional liability and we have urged the Congress to do the same. We also have urged Congress to adopt changes in the fraud and abuse laws which will make enforcement of these laws easier and more meaningful.

With the exception of the Association of Trial Lawyers of America, most professional associations in the legal, medical and business communities agree that the medical malpractice tort system is broken and in need of repair. To the President's credit, he recognized early in his administration the need for medical liability reform and included in his proposed Health Security Act several important reform measures. Under the President's plan nonbinding alternative dispute resolution would be mandatory, plaintiffs would be required to submit a "certificate of merit" from a medical specialist substantiating the claimed injury, and attorneys' fees would be limited to one-third of an award or lower if required by state law.

However, the President's plan falls short of providing a complete comprehensive reform package. In addition to the reforms suggested by the President, the American College of Radiology, a member of the National Medical Liability Reform Coalition (NMLRC), supports a \$250,000 cap on noneconomic damages, a two year statute of limitations, and a further reduction in attorney's fees below the proposed one-third limitation. It should also be spelled out whether or not attorney's costs are included in the fee cap. The ACR urges support for these additional needed reforms.

A final issue of concern to the ACR is the proposal to regulate the number of positions available for graduate medical education and proposed reductions in funding for training physicians. We believe it is inappropriate to arbitrarily decide that funding for training specialists should be reduced. The need for specific specialists should be based on need and not perception. Changing the supply of specific specialties is not a panacea for eliminating what some perceive as inappropriate utilization of medical services. It is more appropriate to determine need for services and provide sufficient numbers of specialists to meet those needs. This will also allow for provision of the most appropriate care by the best qualified physician.

Chairman STARK. Dr. McLean.

STATEMENT OF GORDON K. McLEAN, M.D., PRESIDENT, SOCIETY OF CARDIOVASCULAR AND INTERVENTIONAL RADIOLOGY, AND CHIEF, INTERVENTIONAL RADIOLOGY, WESTERN PENNSYLVANIA HOSPITAL, PITTSBURGH, PA.

Dr. McLEAN. Thank you, Mr. Chairman. My name is Gordon McLean. I am a practicing physician and chief of Interventional Radiology at the Western Pennsylvania Hospital, a 500-bed teaching hospital in Pittsburgh, Pa.

Chairman STARK. Why would I come to see you?

Dr. McLEAN. I would stick tiny catheters in you, take pictures then we fix you, and send you out a new man that same day.

I am also President of the Society of Cardiovascular and Interventional Radiology, which represents nearly 2,000 practicing interventional radiologists in the United States.

We appreciate the opportunity to present our views today. Interventional radiologists provide a broad range of patient care services including the diagnosis, management, and treatment of vascular diseases, as well as certain disorders such as trauma and cancer, which affect the gastrointestinal, genitourinary, and nervous systems. We use a variety of imaging techniques such as fluoroscopy, ultrasound, and computed tomography to guide minimally invasive therapeutic procedures.

The interventional services provided by members of the Society are characterized by two distinguishing features:

First, they are cost-effective alternatives to more expensive surgeries. These procedures provided by interventionalists are also less painful and less risky than their costly surgical alternatives.

Second, our services are characterized by continual innovation. We rely on technologic development to provide a range of exciting new and valuable therapies to patients, many of whom simply would have died in years past. This spirit of innovation is essential to advancing the health of Americans and maintaining the dramatic growth in medical technology exports. Interventional radiology thus promises to simultaneously lower the cost of medical care and to promote innovation in medical technology, a rare combination.

The Society has long been a vocal advocate of meaningful health reform. We have worked extensively with the Health Care Financing Administration on the Resource-Based Relative Value Scale. We have worked with the AMA to improve the CPT codes describing the services we provide. We have also worked with HCFA to ensure consistency in billing across Medicare carriers.

We have participated in the creation of practice guidelines and funded the study of cost-effective patient management. Many of our members are also active in local, regional, and national efforts to improve the health care delivery system.

We strongly support the goals set out by the President and the First Lady: security, simplicity, savings, responsibility, quality and choice. We also advocate many aspects of the proposed reform, especially the provision of universal coverage.

We also have, however, many concerns about the plan as introduced in H.R. 3600. Will "gatekeeper medicine" establish perverse

incentives for primary care physicians to deny or delay access to necessary specialty referrals and tests? Will American medicine continue to have the flexibility to innovate and discover new therapies for patients? Will the medical malpractice proposals, which we believe to be a good first step, be enhanced in the legislative process? We will be addressing these and other issues in written comments to the committee.

Now to move on to the main business of today: cutting \$124 billion out of the Medicare program over and above the cuts enacted in OBRA 1993 and the cuts that resulted from physician payment reform. First, we believe that the overall cuts, for example, as achieved through manipulation of the Medicare Volume Performance Standards are unrealistically and distressingly large, and can be expected to jeopardize the program that serves the elderly and the disabled. Medicare already pays doctors 30 percent less than private insurers, and who will treat Medicare patients if payments are cut more? But further, we would also argue that some of the proposed cuts are structured in such a way that they will undermine the goals and contradict the basic tenets of reform agreed upon by the Congress and members of the physician community in 1989.

In the balance of my time, I will focus on only three of the issues related to the proposed Medicare cuts that are of particular concern: (1) violation of the relative payment levels established in the RBRVS; (2) broad application of the notion of "competitive bidding;" and (3) specialist medical education.

First, a number of provisions in Title IV would arbitrarily change the relative levels of payments for services that have painstakingly been established. While the justifications for these reductions differ, each promises to change relative payments by affecting the volume performance standard and conversion factor, including: the 3 percent reduction in the conversion factor proposed in the act for all services except primary care; the "elimination of the formula driven overpayment"; and a number of the other proposals which operate through the volume performance standard. While these provisions appear to be well intentioned, each will seriously damage the relativities established by the Medicare program.

As you recall, HCFA attempted to establish the relative values in a scientific fashion, engaging researchers from Harvard University and the assistance of the physician community. Our Society has spent a considerable amount of physician time and effort supporting HCFA's and AMA's efforts to obtain accurate relative values. Changes imposed through the political process promise to violate the scientific integrity of the payment schedule, the notion of "equal pay for equal work" established by the Congress, and the trust of physicians.

Second, we also have some concerns about the administration's proposal regarding competitive bidding. When MRI and CT are used as part of interventional procedures, they should not be subject to competitive bid, but, rather, paid according to the physician fee schedule. In addition, we believe that, before the Secretary receives blanket authority to pay for services through the competitive bidding process, it would be desirable to see how competitive bidding works in pilot studies for Medicare.

Last, in order to effectively care for patients, primary care physicians need to refer appropriately to properly trained specialists. It is thus critically important that specialists, especially those providing cost-effective interventional services, be trained and available.

Properly trained interventional radiologists currently undergo a 6-year training program. We are very concerned that the elimination of payment for a major portion of that training, as enacted in OBRA 1993, will jeopardize training quality. Although the proposed legislation does not specify how training funds are to be allocated, we are concerned that the group responsible for medical training may not provide for adequate supply of trained interventionalists.

On behalf of the Society of Cardiovascular and Interventional Radiology, I would like to thank the Committee for your attention to our concerns. All of us want meaningful reform of the health care system. But despite the most vigorous preventive measures and the most brilliant health reform, our Nation's citizens will unfortunately be afflicted by trauma, cancer and atherosclerosis. As interventional radiologists provide cost-effective and high-quality treatment for these conditions, it is critical that the development of this specialty not be thwarted while achieving health system reform.

Again, thank you for the opportunity to present these views.

I also request that we be afforded the opportunity to submit a more comprehensive written statement and that it be included in the hearing record.

Chairman STARK. Without objection.

[The prepared statement follows:]

**TESTIMONY OF GORDON K. McLEAN, M.D.
SOCIETY OF CARDIOVASCULAR AND INTERVENTIONAL RADIOLOGY**

Thank you, Mr. Chairman. My name is Gordon McLean. I am a practicing physician and Chief of Interventional Radiology at the Western Pennsylvania Hospital, a 500-bed teaching hospital in Pittsburgh, Pennsylvania. I am also President of the Society of Cardiovascular and Interventional Radiology, which represents nearly 2000 practicing Interventional Radiologists in the United States.

We appreciate the opportunity to present our views today. Interventional Radiologists provide a broad range of patient care services including the diagnosis, management, and treatment of vascular diseases, as well as certain disorders such as trauma and cancer, which affect the gastrointestinal, genitourinary, and nervous systems. We use a variety of imaging techniques such as fluoroscopy, ultrasound, and computed tomography to guide minimally invasive therapeutic procedures.

The interventional services provided by members of the Society are characterized by two distinguishing features. First, they are cost-effective alternatives to more expensive surgeries. These procedures provided by interventionalists are also less painful and less risky than their costly surgical alternatives. Second, our services are characterized by continual innovation. We rely on technologic development to provide a range of exciting new and valuable therapies to patients, many of whom simply would have died in years past. This spirit of innovation is essential to advancing the health of Americans and maintaining the dramatic growth in medical technology exports. Interventional radiology thus promises to simultaneously lower the cost of medical care and to promote innovation in medical technology -- a rare combination.

The Society has long been a vocal advocate of meaningful health reform. We have worked extensively with the Health Care Financing Administration on the Resource Based Relative Value Scale. We have worked with the AMA to improve the CPT codes describing the services we provide. We have also worked with HCFA to ensure consistency in billing across Medicare carriers. We have participated in the creation of practice guidelines and funded the study of cost-effective patient management. Many of our members are also active in local, regional, and national efforts to improve the health care delivery system.

We strongly support the goals set out by the President and the First Lady: security, simplicity, savings, responsibility, quality and choice. We also advocate many aspects of the proposed reform, especially the provision of universal coverage.

We also have, however, many concerns about the plan as introduced in H.R. 3600. Will "gatekeeper medicine" establish perverse incentives for primary care physicians to deny or delay access to necessary specialty referrals and tests? Will American medicine continue to have the flexibility to innovate and discover new therapies for patients? Will the medical malpractice proposals, which we believe to be a good first step, be enhanced in the legislative process? We will be addressing these and other issues in written comments to the Committee.

Now to move on to the main business of today: cutting \$124 billion out of the Medicare program over and above the cuts enacted in OBRA 1993 and the cuts that resulted from physician payment reform. First, we believe that the overall cuts (e.g., as achieved through manipulation of the Medicare Volume Performance Standards) are unrealistically and distressingly large, and can be expected to jeopardize the program that serves the elderly and the disabled. Medicare already pays doctors 30 percent less than private insurers, and who will treat Medicare patients if payments are cut more? But further, we would also argue that some of the proposed cuts are structured in such a way that they will undermine the goals and contradict the basic tenets of reform agreed upon by the Congress and members of the physician community in 1989.

In the balance of my time, I will focus on only three of the issues related to the proposed Medicare cuts that are of particular concern: (1) violation of the relative payment levels established in the RBRVS; (2) broad application of the notion of "competitive bidding;" and (3) specialist medical education.

1. A number of provisions in Title IV would arbitrarily change the relative levels of payments for services that have painstakingly been established. While the justifications for these reductions differ, each promises to change relative payments by affecting the volume performance standard and conversion factor, including: the three percent reduction in the conversion factor proposed in the Act for all services except primary care; the "elimination of the formula-driven overpayment;" and a number of the other proposals which operate through the volume performance standard. While these provisions appear to be well-intentioned, each will seriously damage the relativities established by the Medicare program. As you recall, HCFA attempted to establish the relative values in a scientific fashion, engaging researchers from Harvard University and the assistance of the physician community. Our Society has spent a considerable amount of physician time and effort supporting HCFA's and AMA's efforts to obtain accurate relative values. Changes imposed through the political process promise to violate the scientific integrity of the payment schedule, the notion of "equal pay for equal work" established by the Congress, and the trust of physicians.

2. We also have some concerns about the Administration's proposal regarding competitive bidding. When MRI and CT are used as part of interventional procedures, they should not be subject to competitive bid, but, rather, paid according to the physician fee schedule. In addition, we believe that, before the Secretary receives blanket authority to pay for services through the competitive bidding process, it would be desirable to see how competitive bidding works in pilot studies for Medicare.

3. In order to effectively care for patients, primary care physicians need to refer appropriately to properly trained specialists. It is thus critically important that specialists, especially those providing cost-effective interventional services, be trained and available. Properly trained interventional radiologists currently undergo a six-year training program. We are very concerned that the elimination of payment for a major portion of that training, as enacted in OBRA 1993, will jeopardize training quality. Although the proposed legislation does not specify how training funds are to be allocated, we are concerned that the group responsible for medical training may not provide for adequate supply of trained interventionalists.

On behalf of the Society of Cardiovascular and Interventional Radiology, I would like to thank the Committee for your attention to our concerns. All of us want meaningful reform of the health care system. But despite the most vigorous preventive measures and the most brilliant health reform, our Nation's citizens will unfortunately be afflicted by trauma, cancer and atherosclerosis. As interventional radiologists provide cost-effective and high quality treatment for these conditions, it is critical that the development of this specialty not be thwarted while achieving health system reform.

Again, thank you for the opportunity to present these views. I also request that we be afforded the opportunity to submit a more comprehensive written statement and that it be included in the hearing record.

APPENDIX TO THE TESTIMONY OF GORDON K. MCLEAN, M.D.

This appendix is a supplement to the testimony of Dr. Gordon McLean on behalf of the Society of Cardiovascular and Interventional Radiology. It expands on the Society's concerns, discussed in the testimony, with the changes to the Medicare program included in President Clinton's Health Security Act. We have also taken the liberty of including some broader health reform issues of importance to our Society. Thank you for the opportunity to supplement the testimony with this appendix.

SAVINGS IN THE MEDICARE PROGRAM

President Clinton's Health Security Act includes \$124 billion in Medicare program cuts over and above the cuts enacted in OBRA 1993 and the cuts that resulted from physician payment reform. Overall, we believe that the cuts are unrealistically and distressingly large, and can be expected to jeopardize the program that serves the elderly and the disabled. Medicare already pays physicians 30 percent less than private insurers. If the dramatic erosion in payment we have seen in recent years continues, who will treat Medicare patients? We also object to many of the ways in which the cuts are structured. Specifically, we believe that, as currently specified in the Act, the Medicare cuts will undermine the goals and contradict the basic tenets of reform agreed upon by the Congress and members of the physician community in 1989.

MEDICARE SAVINGS RELATED TO PART B

Establishment of Cumulative Expenditure Goals (Title IV, Subtitle B, Part 2, Section 4111)

The use of the cumulative Medicare Volume Performance Standard (MVPS) and the cumulative increase in actual expenditures rather than the MVPS and actual spending for the prior year to determine the annual update for the conversion factor will allow adjustments to the conversion factor to compound each year. In conjunction with other adjustments to the MVPS included in the Act, such as the repeal of the maximum allowed reduction (Section 4112), this proposal is likely to institutionalize large reductions to the Medical Economic Index, allowing for only small, if any, increases in the conversion factor. With Medicare reimbursement already significantly lower than other private insurers, we believe that this clause runs counter to Medicare's concern over beneficiaries' access. ***We would ask that this clause be removed from the Health Security Act.***

The Use of Real GDP to Adjust for Volume & Intensity (Title IV, Subtitle B, Part 2, Section 4112)

The replacement of volume and intensity growth with GDP growth in the MVPS for all services except primary care services (for which 1.5 percent plus real GDP growth is used) inappropriately and unrealistically assumes that GDP growth is the correct target for volume and intensity growth in the Medicare program. This assumption ignores the effects of technology and innovation, as well as the service-intensive nature of health care. Volume and intensity (as calculated by the HCFA Medicare Trustees) has grown significantly faster than GDP in the past; the average annual volume and intensity growth between 1986 and 1992 was 6.94 percent while growth in GDP was 2.30 percent. ***We would ask that this clause be removed from the Health Security Act.***

More broadly, we are concerned that this proposal is one of many in the Act that will seriously damage the relativities established by the Medicare program. While the proposal does not directly adjust relative values units (RVUs), the different volume and intensity updates for different types of services will widen the differential in future conversion factors, indirectly affecting the relativities. As you recall, HCFA attempted to establish the relative values in a scientific fashion, engaging researchers from Harvard University and the assistance of the physician community. Our Society has spent a considerable amount of physician time and effort supporting HCFA's and AMA's efforts to obtain accurate relative values. Changes imposed through the political process promise to violate the scientific integrity of the payment schedule, the notion of "equal pay for equal work" established by the Congress, and the trust of physicians.

Repeal of Restriction on Maximum Reduction Permitted (Title IV, Subtitle B, Part 2, Section 4112) The ceiling on the allowed reduction from the Medical Economic Index in calculating the conversion factor was part of an agreement which protected physicians from excessive reductions and the resulting inappropriately low increases in the conversion factor. OBRA 1993 already violated this agreement by increasing the allowed reduction from 3 percent to 5 percent. The Health Security Act completely disregards this agreement by proposing to repeal the restriction. ***We would ask that this clause be removed from the Health Security Act.***

Reduction in Conversion Factor for Physician Fee Schedule for 1995 (Title IV, Subtitle B, Part 2, Section 4113). This one-time, 3 percent reduction in the conversion factor for 1995 for all physician services except primary care represents an arbitrary reduction in physician payment without regard for physician performance as compared to volume performance standards. It completely disregards agreements made with the physician community with respect to the MVPS formula. In addition, as was discussed with respect to the volume and intensity changes, the disparity between primary care and non-primary care services violates the scientific validity of the relativities established by HCFA and the physician community. *We would ask that this clause be removed from the Health Security Act.*

Limitations on Payment for Physicians Services Furnished By High-Cost Hospital Medical Staffs (Title IV, Subtitle B, Part 2, Section 4114) – We believe that the limitation of physician payment based on hospital level average relative values per admission is highly arbitrary and subverts many goals of the Act. We agree with the arguments summarized in the AMA's testimony pertaining the specific provisions of this complicated proposal. In addition, the SCVIR is concerned that this provision penalizes all physicians regardless of whether or not they provide cost-effective services. An interventional radiologist who is part of a "high-cost hospital medical staff" most often provides cost-effective services, yet has no control over the practices of the other physicians on staff. *We would ask that this clause be removed from the Health Security Act.*

Medicare Incentives for Physicians to Provide Primary Care (Title IV, Subtitle B, Part 2, Section 4115)

- **Resource-Based Practice Expense Relative Value Units Study –** The SCVIR supports the development of a resource-based relative value scale for practice expenses. We look forward to assisting the Secretary in developing a methodology for implementation of such a system in 1997. We agree that this reform should be based on a scientific methodology such as that employed to develop the resource based relative value scale for work RVUs.
- **Increase in Practice Expense Relative Value Units for Certain Services –** The Omnibus Budget Reconciliation Act of 1993 already implements a short-term "fix" of practice expense RVUs. What is needed now is a real, permanent revision of practice expense RVUs based on a scientific methodology, such as that being developed through the resource-based practice expense RVU study discussed above. Therefore, we disagree with the arbitrary blanket 10 percent increase in the practice expense relative values for all primary care services proposed in the Act. In addition, the funding of this change with a reduction in the total RVUs for all services except primary care clearly violates the relativity of the payment schedule. *We would ask that this clause be removed from the Health Security Act.*
- **Office Visit Pre- and Post- Time / Office Consultations** The 10 percent increase in work RVUs for office visits funded by both a decrease in total RVUs for office consultations and a further reduction in total RVUs for all services except primary care is again a violation of the relativity of the resource-based relative value scale. In addition, the SCVIR is disturbed that the Physician Payment Review Commission found no legitimate basis for the increase:

The rationale [for this provision] appears to be that time spent before and after visits (so-called pre/post time) is not fully accounted for in the relative values. This is directly contrary to the Commission's conclusion, based on its visit survey, that the Hsiao study systematically over-estimated pre/post time for visits and consultations. Unless it could be demonstrated that there was a systematic error in the other direction in the Hsiao study, arbitrarily increasing office visit relative work values by 10 percent would violate the resource basis of payment.¹

We would ask that this clause be removed from the Health Security Act.

- **Outlier Intensity Relative Value Adjustments** This arbitrary reduction of the work relative values for codes for which the intensity (work RVUs/time) exceed an

¹ "Physician Payment Review Commission Statement on Medicare and Health Care Reform," before the Subcommittee on Health and Environment, Committee on Energy and Commerce, United States House of Representatives, November 18, 1993.

intensity threshold set by the Secretary again violates the scientific integrity of the resource-based relative value scale. Once again, we would point out that the work relative value units were established through the hard work and resources of HCFA, the AMA, and physician specialty societies using a scientific methodology. ***We would ask that this clause be removed from the Health Security Act.***

Application of Competitive Bidding Process for Part B Items and Services (Title IV, Subtitle B, Part 2, Section 4118) The SCVIR is concerned with the Administration's proposal regarding the use of competitive bidding, particularly for MRIs and CAT scans. The Act specifies that competitive bidding should apply to "items and services for which... competitive acquisition... will be appropriate and cost-effective." We are not aware of any evidence that competitive bidding for MRIs and CAT scans will be "appropriate and cost-effective."

However, if competitive bidding for MRIs and CAT scans is mandated, the law must ensure that imaging guidance used as part of medical procedures not be subject to competitive bidding. The imaging services provided by interventional radiologists differ substantially from diagnostic radiology and are not a standardized commodity. To competitively bid MRIs and CAT scans associated with interventional procedures would show a complete misunderstanding of the interrelationship between these procedures and interventional practice.

Finally, we believe that it is inappropriate for the Act to give the Secretary broad discretion to bring competitive bidding to other items and services without further discussion. The expansion of competitive bidding will require the development of explicit guidelines and should not extend to individual services but rather to the management of a disease.

Before the Secretary receives blanket authority to pay for services through competitive bidding, we would ask that pilot studies be completed to show that this technique is both "appropriate and cost-effective" for the services in question. Specifically, when imaging is used as part of interventional procedures, they should be paid according to the physician fee schedule rather than competitive bid. We would ask that the Secretary not be given freedom to extend competitive bidding to other services and items without further discussion. Finally, if this strategy is to be pursued, we believe it should apply to disease management rather than to specific services.

MEDICARE SAVINGS RELATED TO PART A

Reduction in Adjustment for Indirect Medical Education (Title IV, Subtitle B, Part 1, Section 4102) We are also concerned that the reduction in the adjustment for indirect medical education proposed in the Act will jeopardize the availability of training for certain specialties. In order to effectively care for patients, primary care physicians need to refer appropriately to properly trained specialists. It is thus critically important that specialists, especially those providing cost-effective interventional services, be trained and available. We are also concerned that the elimination of payment for more than four years of training, as enacted in OBRA 1993, will jeopardize training quality. Properly trained interventional radiologists currently undergo a six-year training program. Although the proposed legislation does not specify how training funds are to be allocated, we are concerned that the group responsible for medical training may not provide for adequate supply of trained interventionalists. ***We would ask that funding for interventional radiology training be sufficient to maintain an adequate supply.***

Revisions to Payment Adjustments for Disproportionate Share Hospitals in Participating States — The SCVIR is also concerned with the proposed Medicare savings resulting from revisions in the disproportionate share hospital (DSH) payments. Many of our members practice in large urban hospitals, often located in the inner-city. Although the loss of DSH payments is offset by \$800 million in payments for hospitals serving vulnerable populations (Title III, Part 4, Section 3481) and increased insurance coverage, we do not believe that these sources will be sufficient to cover their losses. For example, a recent study by Lewin-VHI estimated that, even after accounting for savings to public hospitals through the coverage of the uninsured, the loss of disproportionate share funds would require a \$3.4 billion increase in local government spending in 1998. Any decrease in the payments to these hospitals could seriously adversely affect patient care, especially as the majority are already experiencing financial instability. ***We would ask that Congress ensure that DSH hospitals continue to be paid adequately for their unique and important contributions.***

OTHER ISSUES RELATED TO THE HEALTH SECURITY ACT

Development and Dissemination of Practice Guidelines (Title V, Subtitle A, Section 5006) The promulgation of practice guidelines will be important to ensure that patients continue to

receive quality and appropriate treatment. The increasing prevalence of a system in which referrals depend upon a "gatekeeper" physician's knowledge of treatment options emphasizes the importance of guideline development. Ideally these guidelines will be developed by scientific study but it will take many years to collect this information for certain diseases and treatments. Absent such scientific research, guidelines, as noted in the Health Security Act, will need to be based on "professional judgment." This professional judgment must be based on multidisciplinary expert panels reviewing practice parameters developed by medical societies, associations, and colleges and the available scientific literature. ***We would ask that interventional radiologists be represented on the expert panels developing practice guidelines for the management of diseases relevant to their practice.***

Financial Incentives To Deny Appropriate Medical Services -- Although not explicitly discussed in the Health Security Act, it is clear that health reform will lead to increased use of gatekeeper medicine. If such a system is adopted, it is critical that financial incentives to deny or delay access to necessary specialty referrals and tests not exist. Specifically, financial incentives that discourage the appropriate provision of medical services must be declared illegal by any health reform legislation.

For example, one Blue Cross/Blue Shield plan used such a financial incentive to change the behavior of its "gatekeeper" physicians. This plan measured the use of referrals and ancillary tests by primary care physicians during a baseline period. Once the plan was established, the use of referrals and ancillary tests by the gatekeeper was monitored and any savings accrued to the plan through a decrease in referrals and ancillary tests were split with the gatekeepers. Unfortunately, outcomes analysis is not exact enough to ferret out reductions in quality which may result from such a strategy. ***We would ask that any health care reform legislation explicitly prohibit such detrimental financial incentives on the part of health plans.***

Specialists as Providers of Cost-Effective Care -- Many of the Act's provisions seem to favor primary care physicians as gatekeepers or the managers of patient care. We would argue, however, that in many cases, specialists can serve this function more effectively. Most patients with chronic health problems already rely on a specialist as a primary contact with the health care system. If a specialist is already intimately familiar with a patient's medical history and comorbidities, requiring the patient to see a primary care physician before going to the specialist for treatment is likely to be wasteful and counterproductive. For example, many healthy women rely on their obstetrician for primary care. Finally, as tertiary care providers, interventionalists often see inappropriate referrals from primary care physicians who do not have a clear understanding of their patients' underlying illness and actively redirect the care of these patients. This improves quality and yields substantial savings. ***We ask that the Health Security Act not penalize health care organizations that designate specialty physicians as the primary point of patient contact. Furthermore, the Act should not discriminate against any specialist as the provider of gatekeeper services.***

Institutional Costs of Graduate Medical Education; Workforce Priorities (Title III, Subtitle A, Part 1) We believe that the manipulation of physician training programs, such as the role proposed by the Act for the National Council on Graduate Medical Education, is not an appropriate mechanism to ensure an adequate supply of physicians in various specialties. Without complete information on the current supply of particular specialties, as well as understanding of how factors such as changing technology and demographics may affect demand, the National Council could easily make allocations across specialties that could lead to a critical shortage. Interventional radiologists are in short supply. Decreasing the supply of physicians from whom interventional radiology fellowships obtain our trainees (diagnostic radiologists) will naturally decrease the number of interventional radiologists available. As we provide highly cost-effective and medically-effective treatments, this would be counterproductive to the goals of health care reform. ***We would ask that the supply of physicians to fulfill various roles in the organized delivery of health care be left to natural market forces and the interest of those who enter the field of medicine.***

The Society thanks the Committee for your attention to our concerns. All of us want meaningful reform of the health care system. But despite the most vigorous preventive measures and the most brilliant health reform, our Nation's citizens will unfortunately be afflicted by trauma, cancer and atherosclerosis. As interventional radiologists provide cost-effective and high quality treatment for these and other conditions, it is critical that the development of this specialty not be thwarted while achieving health system reform.

Chairman STARK. Dr. Shapiro.

**STATEMENT OF HOWARD B. SHAPIRO, Ph.D., DIRECTOR OF
PUBLIC POLICY, AMERICAN COLLEGE OF PHYSICIANS**

Mr. SHAPIRO. Mr. Chairman, the American College of Physicians is the Nation's largest medical specialty society with a membership of 80,000 physicians, along with our colleagues in the American Society of Internal Medicine, we represent internists and subspecialists in internal medicine.

The college approaches the question of additional Medicare savings with decidedly mixed feelings. On the one hand, we are committed to health care reform, and we must put together a sound financing package to achieve reform. We would prefer a broad revenue source for financing, but it does not appear that significant new revenues are politically viable, so Congress is likely to craft a package of spending restraints and new revenues to support health care reform. We will all have to weigh the sacrifices required by the financing package against the benefits of achieving comprehensive reform.

The College has also supported the notion of a national health care budget that will apply to all payers, public and private. We cannot achieve and sustain universal coverage without effective spending restraint. In order to avoid further cost shifting, any Medicare changes must be accomplished within the context of mechanisms to restrain spending on the private side.

On the other hand, some of the numbers raise significant concerns. The proposed reductions represent about 10 percent of projected Medicare spending in the 1995-2000 period, and that is a significantly higher proportionate reduction than Congress has tried to achieve in the past. It comes on top of the \$56 billion in Medicare spending reductions in the 1993 deficit reduction package.

We were struck by numbers cited in the PPRC testimony. Reducing a projected growth rate of 10 percent is one thing, but when 1992 and 1993 growth are down around 4 percent, then we have to ask ourselves if an important shift has occurred that calls into question the growth projections and the need for further reductions to reduce the growth rate. Combined with the PPRC statement that because of large overestimates of the volume offset, past year reductions have achieved greater savings and reduced physicians' revenues more than expected, these numbers serve as a strong cautionary signal as Congress considers any further reductions in Medicare.

Mr. Chairman, our formal statement focuses on recommendations to use Medicare and other tools at your command to shape a national work force policy that recognizes as its centerpiece the need for a greatly expanded supply of physicians who provide comprehensive, integrated, continuous care. We believe that this policy will require a combination of Federal initiatives through a work force commission and fiscal incentives that make the generalist approach to practice a viable option for physicians.

I strongly disagree with a statement made earlier today. When I get outside Washington, I find that whatever else it may have achieved, the Medicare fee schedule has not fulfilled our hopes of

equitable compensation for the core evaluation and management services of the generalist position.

I find that nothing is more demoralizing to generalists and nothing drives physicians away from primary care more than the disparities of revenue potential between proceduralists and nonproceduralists. Payments for the same long hours of service can vary by factors of 10 to 30 times. So the College respectfully disagrees with representatives of other organizations in our approach to the Medicare fee schedule.

We appreciate the administration's recommendations to boost compensation for primary care and urge this subcommittee to consider them favorably.

Thank you for this opportunity to share our thoughts with you.
[The prepared statement follows:]

**STATEMENT OF
THE AMERICAN COLLEGE OF PHYSICIANS
TO THE HOUSE WAYS AND MEANS SUBCOMMITTEE ON HEALTH
November 23, 1993**

Medicare and Health System Reform

Thank you for the opportunity to testify on the topic of Medicare under a reformed health care system. I am Howard B. Shapiro, PhD, Director of Public Policy for the American College of Physicians. With a membership of 80,000 internists, ACP is the nation's largest medical specialty society. No set of physicians provides more care under the Medicare program than internists.

We begin with the assumption that Medicare will remain a separate program, certainly during a transition period and at least for the foreseeable future after health care reform is implemented. It is essential therefore that Congress and the Department of Health and Human Services continue to take steps to improve the program, as well as to prepare for Medicare's role under comprehensive reform.

Developing a National Workforce Policy

We would like to concentrate today on the question of workforce, or physician supply. This issue, critical for the future of our system, allows us to think about a set of functions of the Medicare program, particularly payment for graduate medical education and the payment and practice environment of physicians.

As a matter of national policy, we have to choose what we want the physician workforce of the future to look like. Should the workforce consist largely of subspecialists, each caring for a disease or organ system using its particular set of technologies or procedures? Or should the workforce have as its core physicians who are generalists, whose comprehensive, continuing care of patients is supplemented as necessary by subspecialists?

If we do not choose by creating policy, then we will choose by default. Extrapolating current trends, default leads to a workforce of subspecialists, with the primary care or generalist physician playing a role on the periphery, or no role at all.

As this Subcommittee well knows, only a small fraction of graduating medical school seniors express interest in the generalist specialties. This translates into unfilled slots in residency programs; for example, less than 60 percent of the slots in internal medicine are now filled by graduates of US schools. Our current mix of 35 percent generalists and 65 percent specialists threatens to become more unbalanced if we do not reverse the explosive growth of subspecialty training over the past decade.

A national policy on the physician workforce must lay out where we want to go and how we're going to get there. As part of health care reform, Congress must direct the development of that policy. A central goal must be to meet the need for comprehensive, continuing patient care provided by generalist physicians.

The College supports proposals for a national workforce commission, with authority to determine the numbers of residency training positions and to allocate slots among graduate medical education programs. This commission must have the clout to back up its allocation decisions through the funding of training positions. Therefore, our concurrent recommendation is that Medicare and all other payers be assessed a percentage of service dollars. Those funds should be pooled for the funding of approved positions.

The Administration has incorporated these ideas into its proposal for a National Council on Graduate Medical Education. This Council would make allocations of specialty training positions among eligible programs accredited by the American Council on Graduate Medical Education and the American Osteopathic Association. We believe that legislation should provide a specific role for these private accrediting agencies in distinguishing among programs based on quality.

Under the President's proposal, Medicare funds for graduate education would be pooled with funds from health alliances. We agree that all payers should share this responsibility. Payments would be made for the direct costs of residents—salaries, faculty supervision, and related costs—much as Medicare direct payments are made now. Payments for the specialized care and services of academic health centers would be made as well, but without adjustment for indigent care as is currently done through the Medicare indirect GME payments. We concur strongly with the President's proposal that current restrictions on the use of funds for training

in ambulatory settings should be eliminated.

We are concerned about the proposed caps on total payments for direct and indirect GME. In the past, there have been no restrictions on the amounts that could be collected from non-Medicare sources for training purposes. The Clinton plan does not indicate explicitly that teaching hospitals cannot obtain GME funding from other sources beyond the pool, but cost-shifting within patient care revenues will become difficult as each health plan is pressured by regional and corporate health care alliances to keep prices low.

Under a national workforce policy as implemented by a new commission, there should be no need for limits on funding for a specific number of years of training. Adequate funding must be available for all approved residencies, including subspecialties.

We have not been convinced that weighting payments to support residencies in the generalist specialties would have much effect on influencing student career choices, unless perhaps the differences in weights were very substantial. The weighting factors determine payments to institutions, not physicians-in-training. Differences in the revenue potential among hospital services remain much more potent factors in determining the attractiveness of residencies. Stipends vary relatively little among institutions or types of residents, and are not likely to be adjusted by differences in Medicare direct GME payments.

Finally, it will be important to provide transition funding to meet the service needs of teaching hospitals. As you know, GME payments are used to provide direct services, especially in urban areas. As the number and mix of residents and fellows are changed, these hospitals and the patients they serve will be placed at a disadvantage. They will need transition funding as they move to replace the residents who have provided these services.

Physician Payment Policy

At the same time that we take steps to develop and implement a national workforce policy, we must create a payment and practice environment that will foster a commitment among medical students and physicians to provide primary care.

The Medicare Fee Schedule remains the most significant force in this arena, particularly for internists whose practice may be 60 or 70 percent Medicare patients. The MFS will continue to be utilized by the Medicare program and may well serve as a model for setting compensation in fee-for-service and other types of health plans. For this reason, we urge this Subcommittee to continue to assess and correct problems in the fee schedule.

In April, the College asked the Administration to send a dramatic signal to internists and others delivering primary care that they would be highly valued in a reformed health care system. We recommended that payments for evaluation and management services under the MFS be doubled. The Administration responded to this recommendation with a series of proposals in the Health Security Act that would increase these payments and also protect primary care services from further reductions.

The proposals include adding relative values to better account for pre- and post-encounter work, increasing the overhead expense relative values, and others. Pending an examination of actuarial estimates of their impact, we are supportive of these efforts, although we have reservations about one in particular--the proposal to eliminate separate payments for consultations and fold that funding into payments for visits. That appears to be taking money from one set of evaluation and management services and giving it to another.

One anomaly in the original legislation creating the Medicare Fee Schedule must be corrected. While payments for physician work moved to a calculation based on the resources consumed, payments for the overhead expense component continue to be based on the historical relationship of average practice expenses to overall charges. Because the practice expense component determines about 40 percent of the fee schedule payment, this factor continues to work against primary care services. As part of health reform legislation, Congress must direct the Department of HHS to implement a resource-based practice cost calculation. The Physician Payment Review Commission is supportive of this recommendation.

On a broader level, Mr. Chairman, the consideration of health care reform legislation perhaps gives us the opportunity to go back to basics, to question the assumptions of our payment system and its impact on physician practice. Even if we were to make substantial improvements in payment for office and hospital visits, we still continue to value procedure time far more than we value evaluation and management time. Few things are more discouraging to physicians who provide primary care services than to work the same long hours as procedural specialists and be rewarded with payments that are lower by factors of ten to thirty.

How can we differentiate a comprehensive examination of an elderly patient with multiple organ system problems from the comprehensive examination of the knee? Can we ever expect

to capture in a procedurally-oriented coding system the complex web of diagnostic, therapeutic, preventive and counseling services that the internist may provide in a one-hour encounter with a patient? These and similar questions must be answered if, over the long term, we are to develop a set of financial incentives that restores primary care to its essential position in health care delivery.

Conclusion

Mr. Chairman, the College urges this Subcommittee to use these components of the Medicare program and other tools at your command to shape a health care system that will redress the balance in the physician workforce. As the country extends coverage to millions of Americans--and, of equal importance--as we face an enormous increase in the number of elderly people over the next several decades--the demand for physicians who provide integrated, continuing care of patients will soon outstrip the supply. Consideration of health care reform legislation provides the opportunity for a comprehensive review and restructuring of policies that will affect the nation's capacity to meet this demand.

Chairman STARK. I want to thank the panel.

In general, I share your concerns, Dr. Shapiro. What you say makes good sense to me and some of my reimbursement I get from my home area, but if Kaiser is starting family practitioners around \$110,000, \$120,000 a year and we hear that the University of California has 14 "partners" on the inside making \$70,000, \$80,000, \$900,000 a year in the teaching structure, while the rest of the faculty may not make a third or a quarter of that, I would submit if there is not professional jealousy, the wives or the spouses of those physicians are letting them know at home that they are in the wrong group if they are not among the ones making those high six-figure incomes. That is something—you have to work that out.

But I do think that we have the genesis of an idea here of letting you all determine among yourselves how you want to agree or disagree as to the relative value of your time, your effort, your training and how that ought to be translated. We then have to get into the issue of how much we have.

We can't raise enough taxes, but we have to pay you and we have to deal together with how we are going to take what resources we do have and how we are going to divide them up to take care of folks who need medical care. I think we are approaching that.

I think, Dr. Wallace, you raised the issue of bundling. When you come from an area like mine where half the people in the county in which my district is belong to Kaiser, 600,000 people belong to one HMO, all-staff model, which is the penultimate bundling, I would be the last one to suggest that we ought to make that the standard for Virginia. My guess is that 15 years from now, after you and I have retired, we are going to find a lot more of that going on in Virginia, probably more like they do in California, but I think that is going on regardless of what we do.

If we never legislate, I think more young people coming into the practice of radiology will end up working for a salary, working in group practices. I think that is moving along. It doesn't make any difference to me. That is something that will move ahead.

I think, also, Dr. McLean mentioned the concern of gatekeepers. That is a concern to me.

On the one hand, we have spent the past 10 years figuring out how we can stop overutilization. Now we have to train a whole new bunch of junkyard dogs to stop underutilization, and the pendulum is going to swing the other way. You have to make those decisions.

I cannot envision a computer or 800 number or MBA or hospital administrator that the public is going to give that authority to. How are you going to fight that out? I think that is something you will have to do.

Let me ask you this. If what I am hearing is that with the RBRVS and some method of negotiating as to the conversion and our staying out of the negotiation, as between how those scales are established—and then there will be problems showing up, there will be things you have overlooked. This isn't fair, and you are going to have to figure that out.

We have been asked to in the past, and we got into trouble. We got into trouble on the EKG thing. I am not sure we made the right choice there, but we heard a lot from radiologists. I am not sure

that the primary care guys got a fair cut on that. That is something that you all should have battled out and not us.

Assume that I am right, that the trend toward bundling managed care, group practice, staff model HMOs is going to continue—and I look forward 10 years from now can we continue to use this RBRVS as a basis to set salaries?

If you start an HMO and hire a bunch of guys and pay them \$100,000 apiece—if you were the salary group, could you use the Resource-Based Relative Value Scale as a basis to determine how much you are going to pay a radiologist and how much you are going to pay a surgeon; or once you get out of the fee-for-services, do we have to throw that away and start over?

Dr. EVANS. Mr. Chairman, why not rely on the volume performance standards? Your subcommittee went through this with the American College of Surgeons and tried to develop a system which would work effectively—

Chairman STARK. You have to have both. You can't just pick volume. You also have to figure what you are going to pay people.

Dr. EVANS. You do, but the idea is, if there were less reimbursement per individual procedure, the volume would go up.

Chairman STARK. But how do you decide between the surgeon and the primary care guy what you are going to pay in salary?

Say you are going to do this entirely, Dr. Wallace's worst dream comes true, and we bundle the whole package. We are going to have all staff model HMOs. I am asking, is this structure, the information we will gather and the bargaining, is the Resource-Based Relative Value Scale a useful tool in setting a salary?

Dr. MCLEAN. There are certain inequities inherent in the system that are perpetuated in the practice expense RV's. Dr. Eisenberg referred to this earlier today. We would encourage the use of the simple work unit RV's as the most equitable part of the RBRVS.

Chairman STARK. We are setting salary. In a staff model, all you are getting paid in a salary is your professional component; bean counters who run the HMO are dealing with the linen supply and the rent and the utilities.

Dr. WALLACE. Mr. Chairman, there is perhaps one example I might offer and that is in the government program, such as the Veterans' Administration and in military medical care, basically everybody receives the same base salary. However, from time to time, there have been physician differentials, bonuses of one kind or another because of market forces that apply to that base salary situation, being able to recruit and retain certain specialties.

Chairman STARK. That has been the kind of thing you recommend we do to encourage general practice, is offer bonuses at that end of the scale to encourage more people to come in, rather than tinker with RBRVS. I know it is hard for people who are in fee-for-service to project and say "what if."

Dr. EVANS. Actually, if you look at the Kaiser model in the Bay Area, they are not just a simple, salaried group. Those individuals have incentives. For instance, in the open-base group, there are incentives for additional procedures that are done beyond what your baseline is. Or if you are in obstetrics and gynecology, the number of deliveries done beyond your baseline, so there is still an incentive plan used. The harder you work, the more you make.

Chairman STARK. That is true in Canada.

I am just saying—to set the baseline, I am just wondering whether we have a good thing going here and we can use it in a variety of compensation plans, or if it loses its ability to be useful—forget outside the fee-for-service.

Mr. SHAPIRO. I am not sure that we have a good thing going. We continue to value procedure time within RBRVS far more than we value evaluation and management time. That is number one.

Number two, we have tied RBRVS to a procedurally oriented coding system in which the generalist has a few dozen codes to describe basically all of his or her services, and the proceduralist has several thousand codes, many with minute differences, to describe services.

How do you capture in a procedurally oriented coding system the complex web of diagnostic and therapeutic and preventive and counseling services that an internist may provide in a 1-hour encounter with a patient? What happens is that a physician performs an entire array of services that he or she has been trained to do and that he or she thinks is providing great service to a patient, and is; but then has to affix a code, and RBRVS sets a payment attached to that code, and the payment comes up at \$35 or \$60, and the internist feels that he or she has been clobbered.

Chairman STARK. I am sympathetic to what you are saying, that a group of specialists should receive four times more, say, than pediatricians, on average, troubles me. I don't know what I can do about it, but it doesn't sound quite right to me. It sounds less right when I think of how we are going to get more pediatricians into areas where I think we need that service, or family practitioners.

My simple answer is not to mess around with the training structure but just to pay them more. But that is tinkering with the system. I would rather you all figured that out and that we just had to deal—it is so much easier for us to deal with the conversion factor.

Mr. SHAPIRO. I have heard you say many times that you all figure out the relative values. But, in fact, there are public policy implications to that if we are going to extend access to millions of Americans. We are facing an enormous increase in the elderly population over the next decades, and there is a severe shortage of primary care physicians, and that is a policy problem that Congress has to grapple with.

Chairman STARK. I thought we had it all figured out and could put it on automatic pilot and you guys could solve that for us. I agree with you that absent some kind of an overall look at this that just to ratchet down Medicare without considering the rest of the system is difficult; and I don't know what we are going to do as the year unfolds.

I am, as you can gather, somewhat skeptical about such a complex system as the President's plan envisions. I am not sure what it does that we couldn't do with existing structures; and understanding that, I think they are far from perfect, and there is a lot of work to be done to fix them.

I don't know that we should just completely wipe the slate clean and start all over. I think we have made some progress, and I know that all of you and your groups have worked with us, as I

think everybody has, in good faith, trying to figure out how we can control the rate of increase. That has truly been our goal, and not to have somebody take a tremendous decrease in pay, although I think that the rates of increase or the pay levels will come closer together over time. That is my guess.

I don't think it will be very popular with those who have higher-paid procedural practices, but I appreciate even those people sticking with us.

And so your testimony is appreciated, and I think, I hope you will continue to work with us over the next year to see whether we can get a start, principally on bringing in the uninsured and providing access to the low income, because I think there is a problem there. And you haven't touched on Medicaid, which is even a lower payer than is Medicare. I think if we get rid of that, we make a big start.

I am not as worried about the limitation of access to Medicare as I am of the fact that we aren't going to find access for the very poorest people in this country who are basically in the Medicaid program.

So stick with us. We appreciate your willingness to cooperate, and we will try and—like American Airlines, we have to fuss every 4 or 5 years for a few days before Thanksgiving, then we can declare victory and negotiate in good faith and you all can continue to run a good medical system.

Thank you very much.

Chairman STARK. Our final panel consists of Hope Foster, general counsel for the American Clinical Laboratory Association; Paul Willging, the executive vice president of the American Health Care Association; Mark Zawiski, the southeast regional director of the National Renal Administrators Association; Val Halamandaris, president of the National Association for Home Care; and Michael Tracey, representing the National Association for Medical Equipment Services.

Welcome to the committee.

Ms. Foster.

STATEMENT OF HOPE FOSTER, GENERAL COUNSEL, AMERICAN CLINICAL LABORATORY ASSOCIATION

Ms. FOSTER. I want to commend you on your tenacity here today. My name is Hope Foster. I am the general counsel of the American Clinical Laboratory Association, an organization of federally regulated, independent, clinical laboratories. ACLA appreciates the opportunity, first, to comment on the Medicare cuts that are proposed in the President's Health Security Act, and then to briefly discuss our laboratory reform plan that we have previously shared with you and your staff.

The President's Health Security Act includes two Medicare provisions that would directly affect laboratories: the reimposition of co-insurance on beneficiaries and the use of competitive bidding to purchase laboratory services.

As other witnesses have already stated here today, these proposals represent poor health care policy. They are poor policy because they would result in significant reductions in Medicare payment for

laboratory services, which would adversely affect both laboratories and the beneficiaries who need testing services.

According to administration estimates, the two provisions would lower Medicare spending over 5 years by \$9.18 billion, an amount that is 2.5 times what Medicare part B spent on all laboratory services in 1992. These cuts would be imposed on top of the \$3.3 billion in reductions that were mandated by OBRA '93. Taken together, the cuts included in OBRA and those proposed in the President's Health Security Act would constitute a decrease of approximately 40 percent in Medicare payments to laboratories, a reduction that seems especially excessive in view of the fact that laboratories only represent about 5 percent of Medicare expenditures.

As I noted when I began, the plan would reimpose on Medicare beneficiaries a 20 percent coinsurance requirement for laboratory testing. Both the AARP and the National Committee to Preserve Social Security and Medicare expressed serious concern about this proposal earlier during this hearing. Congress eliminated this requirement in 1984 when the current fee schedule methodology was adopted, which set fees at 60 percent of the then prevailing levels.

The problem with coinsurance is that because of the costs of billing and collection, the requirement would in effect be an additional cut in Medicare laboratory reimbursement. ACLA members conservatively estimate that this de facto reduction would be about 15 percent.

Although the cost of coinsurance is just a few dollars per unit, it would usually cost more than this amount to generate the additional invoice required to bill it. Experience also shows that laboratories typically must write off a large percentage of billed coinsurance because of uncollectibility.

Finally, because patients don't order testing or choose the laboratory to perform the service, the coinsurance is likely to affect utilization of these services, a fact recognized by CBO in a 1990 report.

The administration's plan would also permit the adoption of a winner-take-all competitive bidding procedure for laboratory services. If the procedure did not result in a 10 percent outlay reduction, the Secretary would have authority to order further cuts to achieve such a reduction.

In the past, when government entities tried such arrangements, quality was seriously compromised because some providers submitted low-ball bids and then could not afford to provide services at the winning price. As a result, the patient's health was placed at risk. In a 1984 report, HCFA itself expressed concerns about such proposals and Congress repeatedly blocked implementation of such a plan through statutory moratoria.

Furthermore, the plan proposed by the administration could result in reduced access for patients because losing bidders might well have difficulty remaining in operation and some smaller laboratories might not be able to participate at all if they did not serve the broad geographic area required by the plan.

Finally, the plan's requirement for a minimum 10 percent reduction in expenditures fails to consider whether such cuts are reasonable or justified. In a letter to Members of Congress that is attached to our written statement, 11 groups representing a cross-section of those involved in the delivery of laboratory services

agreed that these proposals threaten the ability of laboratories to continue to provide high-quality services to all who need them. Others testifying here today have discussed their problems with competitive bidding for Medicare.

ACLA does recognize the need for reform of the health care system, including the system in which laboratories operate. That is why this past spring ACLA adopted its own proposal. The centerpiece of that plan is the enactment of a Federal law mandating direct billing of laboratory services, a provision that would require the laboratory that performs the testing to bill the patient or insurer for those services and thereby eliminate markup.

A recent study conducted by the Center for Health Policy Studies concluded that enactment of a national direct billing law would result in annual savings of between \$2.4 and \$3.2 billion through reduced utilization and lower prices, or between \$12 and \$16 billion over the next 5 years.

ACLA's plan also calls for the establishment of payment caps on laboratory reimbursement from private payers similar to Medicare's. Adoption of this provision would lead to additional savings in laboratory payments from the private sector.

Because of the shortage of time, I cannot discuss the other parts of ACLA's proposal. However, we would be happy to discuss them further at any time. Thank you for your consideration. I would be happy to answer any questions.

[The prepared statement and attachments follow:]



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**STATEMENT OF THE
AMERICAN CLINICAL LABORATORY ASSOCIATION
REGARDING MEDICARE CUTS
INCLUDED IN HEALTH CARE REFORM**

November 23, 1993

The American Clinical Laboratory Association ("ACLA") is pleased to have this opportunity to comment on the Medicare cuts that are included in the President's Health Security Act, and their impact on the laboratory industry. ACLA is an association of federally regulated, independent clinical laboratories and represents national, regional and local laboratories located throughout the United States. All ACLA members will be significantly affected by these proposals.

Laboratory testing is an important, cost-effective and life-saving health care tool, which permits the early detection and treatment of a variety of diseases and conditions. Just a few examples illustrate its importance. Testing for cholesterol and related measurements for HDL and LDL help reduce the risk of heart disease. Pap smear screening has led to significant reductions in deaths from cervical cancer. A simple screening test given to newborn babies detects PKU, a metabolic disorder that is treatable if caught early, but which can lead to retardation if left undiscovered. Other tests are routinely used to monitor the effectiveness of medication given to treat cancer and other serious diseases. In short, the early diagnosis and effective treatment permitted by appropriate testing ultimately enhances health, saves lives and reduces costs.

In our statement today, we will first address the laboratory reimbursement reductions included in the President's plan. Then we will discuss the health care reform plan that ACLA proposed in March 1993. ACLA believes that its plan represents a thoughtful and reasonable course for reforming clinical laboratory reimbursement.

**A. The Administration's New Cuts Will Have an Adverse
Effect on the Provision of Laboratory Services**

ACLA welcomes this opportunity to appear today to discuss the Medicare cuts that are included in the President's Health Security Act, and that would be used to finance a portion of the cost of health care reform. ACLA has always recognized its responsibility to accept reductions in reimbursement when necessary. In the past, we have frequently worked with this Committee in crafting appropriate and equitable decreases in laboratory reimbursement to help bring about necessary deficit reduction. The proposals included in OBRA'93, which will reduce laboratory reimbursement by more than \$3.3 billion over the next five years, were developed with significant input from ACLA.

Today, we are here to discuss still further cuts in Medicare reimbursement for laboratories. The President's plan would reimpose laboratory coinsurance obligations on Medicare beneficiaries, a provision that Congress eliminated in 1984 with the support of HCFA and the laboratory industry, when the current fee schedule methodology was adopted. In addition, the President's plan would also authorize the use of competitive bidding to purchase laboratory services for Medicare. While ACLA is committed to the need for meaningful health care reform, we believe these proposals represent faulty health care policy that would ultimately have a significant, deleterious effect on the laboratory industry.

According to Administration estimates, these provisions would reduce Medicare payments to laboratories by approximately \$9.2 billion. This cut is more than two and a half times what Medicare Part B spent on laboratory services in all of 1992. Furthermore, the proposed reductions, in combination with those already mandated by OBRA'93, which Congress just passed last August, would constitute a total decrease of approximately 40 percent in Medicare payments to laboratories. These reductions seem especially unfair in view of the fact that laboratories only represent about 5 percent of total Medicare expenditures. As stated in a recent letter to all Members of Congress, which was signed by 11 groups representing a cross section of those involved in the laboratory industry, these cuts "will threaten the ability of laboratories to provide high quality services; to employ the most qualified individuals; and to ensure that all Medicare beneficiaries enjoy access to necessary laboratory services." A copy of that letter is attached.

ACLA does not object to appropriate changes in the manner in which clinical laboratories must operate. As discussed below, the health reform plan adopted by ACLA would lower utilization of laboratory services and reduce the amount that all payors spend on such services by between \$12 billion and \$15 billion over five years. However, the Administration's proposals will ultimately injure both laboratories and beneficiaries alike.

I. Competitive bidding will harm access and quality

Section 4119 of the Administration's plan would establish a competitive bidding procedure for the acquisition of laboratory services. Although the actual procedures are unclear in the bill, it appears to create a "winner take all" approach, which would give the laboratory awarded the contract the exclusive right to provide laboratory services within a given geographic area. In addition, the plan states that if the competitive bidding plan procedure did not result in a 10 percent savings, the Secretary would have the authority to order further cuts to achieve a reduction of this amount.

ACLA has numerous concerns about this competitive bidding proposal. First, previous federal use of competitive bidding for laboratory services has been unsuccessful. When the Air Force awarded a contract to a laboratory for screening Pap smears on the basis of competitive bidding, the laboratory, which won the contract based on submitting the lowest bid, performed so negligently that women's lives were placed at risk. The Air Force was forced to impound over 700,000 Pap smears that they found contained numerous errors. Other experiments with competitive bidding have encountered similar difficulties.

In the mid-1980s, HCFA contracted with Abt Associates of Cambridge, Massachusetts to design, implement and evaluate a competitive bidding demonstration project for laboratory testing. However, that proposal, which many laboratories believed had significant structural problems that made it unworkable, was never implemented or tested nor was it ever the subject of full-blown public comment. Indeed, for several years, Congress passed a moratorium as part of the HHS appropriations bill which prevented the agency from spending any government funds to implement the Abt proposal.

The "winner take all" arrangement included in the Administration's plan is especially problematic. Under these types of plans, there would be a strong incentive for a bidder to submit a "low ball" bid, in order to obtain the contract, a fact that could have disastrous implications for the quality of the testing. In fact, in 1984, a HCFA report on the laboratory industry expressed great skepticism over competitive bidding. It noted that under a competitive bidding system:

[I]aboratories might knowingly underprice the competition in order to win a Medicare contract, even if they know they will be unable to cover their costs at the bid price. This practice, known as "low-balling," has occurred in even limited competitive contracts for services awarded by the Air Force and by the District of Columbia.^{1/}

^{1/} HCFA, *Report of Laboratory Task Force* at 23 (1984).

Further, the Administration's plan could actually lead to reduced access for many Medicare beneficiaries. Because Medicare amounts to a large percentage of many laboratories' revenues, a laboratory might find it difficult to survive if it were unable to continue to provide services because it was a "losing" bidder. Similarly, it is unclear whether physician office and hospital laboratories would be able to participate under the Administration's plan. Because they often do not serve as broad an area as independent laboratories, they might find it difficult to compete under the plan.

In addition, physicians often have strong preferences about which laboratory they wish to serve their patients. Laboratories have different levels of quality and service; therefore, a physician may prefer one laboratory over another. A competitive bidding arrangement would reduce the ability of the physician to choose the laboratory that he wants to serve his patients.

Finally, the Administration's proposal would require a minimum 10 percent reduction in expenditures, if such savings were not achieved by competitive bidding. This is a wholly arbitrary standard that does not consider whether the reductions are reasonable or justified. In short, the competitive bidding mechanism envisioned by the Administration's plan would threaten the ability of laboratories to provide high quality services and the access to such services enjoyed by beneficiaries.

2. Coinurance represents an additional cut in reimbursement

ACLA must also object to the reimposition of coinurance for laboratory testing provided to Medicare beneficiaries. This requirement was eliminated by Congress in 1984, with the approval of the laboratory industry and HCFA, when the current fee schedule methodology was adopted. The reimposition of this requirement would add to the health care costs already borne by Medicare beneficiaries and have an injurious effect on laboratories.

Imposition of coinurance would, in actuality, constitute a cut in laboratory reimbursement because in many instances, the cost of billing the coinurance would exceed the amount collected. Although the amount of the coinurance is usually just a few dollars, on average, it would cost between \$3.00 and \$5.00 just to produce the additional invoice covering the coinurance, a cost that could easily exceed the amount collected.

Further, in most instances, the cost of collection would be even higher than \$3.00 to \$5.00. If the patient did not pay after receiving the first statement and follow-up were necessary, the costs to the laboratory would obviously increase. Furthermore, past experience with coinurance suggests that in many instances, laboratories would have to write off from 20 to 50 percent of the billed amounts because of uncollectability. Indeed, these problems are the very reason that Congress eliminated the coinurance requirement in 1984 and mandated the current methodology, which set fee schedules at 60 percent of then-prevailing charges.

Furthermore, reinstatement of coinurance would have a negative impact on beneficiaries because it would force them to incur higher outlays and could reduce their access to laboratory services. As noted above, reimposition of coinurance amounts to a substantial cut in reimbursement for laboratories, a cut of at least 15 percent, according to ACLA members. This reduction, coupled with the cuts imposed by OBRA'93 and previous budget laws, could adversely affect both the quality of the services that laboratories are able to provide and the access to services that beneficiaries currently enjoy.

Finally, coinurance for laboratory services would have no effect on utilization of laboratory services. For ancillary services, such as laboratory testing, imposition of copayment obligations on Medicare beneficiaries will not curtail utilization because patients do not decide when to order testing nor do they select the testing laboratory. Medicare covered laboratory services can only be ordered by physicians. As the Congressional Budget Office noted in a 1990 Report:

Cost-sharing probably would not affect enrollees' use of laboratory services substantially, ...because decisions about what tests are

appropriate are generally left to physicians, whose decisions do not appear to depend on enrollees' cost sharing.^{2/}

In sum, while ACLA supports the need for health care reform, we believe both competitive bidding and coinsurance will have a significant, adverse effect on the laboratory industry and the ability of beneficiaries to obtain quality laboratory services.

B. ACLA's Health Reform Plan

ACLA does recognize, however, that health care reform, including reform of the laboratory industry, is urgently needed. ACLA has frequently come before this Subcommittee and urged the enactment of legislation that would bring about significant structural reform of the manner in which laboratory testing is delivered. Earlier this year, in March 1993, ACLA adopted its own health reform plan, which it presented to this Subcommittee during consideration of OBRA'93.

In crafting our reform plan for laboratories, ACLA was guided by three overriding principles. First, such a plan should promote a more cost-conscious and efficient health care system. Second, it should ensure that all patients have access to high quality laboratory testing. Third, it should simplify the rules and procedures that govern the system.

The plan that ACLA drafted in March promotes all three goals. First, it would promote a more efficient system by eliminating those features that lead to overutilization of, and excessive prices for, laboratory testing. It would also end wasteful cost-shifting and impose meaningful cost-containment controls.

Second, ACLA's plan would ensure access to high quality laboratory testing for all those who need it. ACLA continues its long-held support for the goals of CLIA'88, and opposes any wholesale rollback of the law's safeguards. Further, as noted above, we must oppose the Administration's competitive bidding and coinsurance proposals because they will have a significant, and deleterious, impact on the quality of laboratory testing.

Third, the ACLA plan would simplify the system by establishing a process to clarify the rules covering certain types of laboratory tests. And, it would require that the current Medicare system, which unnecessarily relies on over 33 different carriers, all with their own rules and procedures, be streamlined and centralized.

ACLA's plan is a comprehensive program and will only achieve its goals if all of its components are adopted. In our testimony today, we would like to explain why reform of the industry is so urgently needed and how our proposal will help achieve the goals set out above.

1. Promote a Cost-Conscious and Efficient System.

In encouraging cost-consciousness and efficiency in the laboratory industry, ACLA would rely on the rules that Congress has already developed to reduce laboratory utilization and costs in the Medicare program. Several of these provisions, including a direct billing mandate and a system of payment caps, have worked well for Medicare and should be extended to other payors. In our view, a primary reason that the system is in need of reform is that these safeguards have only been applied to Medicare rather than to all payors.

a. Extension of direct billing mandate to all payors

The centerpiece of the ACLA plan is the enactment of a federal law mandating direct billing of laboratory services; i.e., a requirement that the laboratory that performs the testing bill the patient or insurer for those services. This provision would simplify the structure of the industry and lead to a more rational, and efficient, market for laboratory services. Direct billing is required by H.R. 200, which Chairman Stark introduced earlier this year, and by S.337, which Senators Jeff Bingaman and Howard Metzenbaum sponsored.

² CBO, "Reducing the Deficit: Spending and Revenue Options" at 140 (February, 1990).

Enactment of such a requirement would promote a more cost-conscious and efficient system for delivery of testing services than currently exists. Today, laboratories are not required to bill the patient or responsible third-party payor for testing. As a result, physicians often request that they be billed for the testing that they order for their non-Medicare patients. The physician can then mark up this testing, often by a significant amount, when he bills the patient or the appropriate third-party payor. This system can lead to increased testing because it gives the physician the ability to profit from his own test ordering, just as in the case of self-referral.

Because of the concerns raised by this practice, the federal government has prohibited it in the case of Medicare. The Medicare law requires the laboratory that performs the testing to bill the Program directly in most cases. The laboratory is barred from billing the physician that ordered the services. Thus, enactment of direct billing would simply extend the benefits of the Medicare rule to private payors and patients.

Enactment of direct billing would have several important benefits. Most significantly, it would result in reduced utilization of laboratory testing and lower costs as found in a recent study conducted by the Center for Health Policy Studies ("CHPS"). CHPS compared the experience of Medicare and Blue Cross/Blue Shield plans in direct billing and non-direct billing states. The CHPS report, which we have previously supplied to Members of the Subcommittee, found that laboratory prices and utilization were dramatically higher in non-direct billing states than in states that require direct billing. Among the study's findings were the following:

- Charges for laboratory services were 8.4 to 9.6% higher in non-direct billing states than in direct billing states.
- Laboratory utilization per enrollee was higher in non-direct billing states than in direct billing states. For tests reimbursed by Medicare, utilization was 6.5% higher and for tests reimbursed by private payors--where incentives for overutilization are greatest--it was 28.3% higher.
- Laboratory charges per enrollee under private health insurance programs, a measurement that takes into account both utilization and price differences, were 40.6% higher in non-direct billing states.

The report concludes that if a national direct billing law were enacted, annual savings in health care expenditures of between \$2.4 and \$3.2 billion could be achieved, as a result of reduced utilization and lower prices. This translates into savings of between \$12 and \$16 billion over the next five years.

It is particularly appropriate that we should come before this Subcommittee today to discuss direct billing. This Subcommittee has supported the elimination of incentives that increase the use of laboratory testing. It was instrumental in enacting limits on the practice of self-referral in the clinical laboratory industry because of the practice's effect on utilization. The Chairman has co-sponsored legislation that would make these limits applicable to services reimbursed by private payors, as well as Medicare and Medicaid, an effort that ACLA supports. The enactment of direct billing would complete that effort by eliminating another practice that provides an incentive for increased use of laboratory testing.

b. Reduce Cost-Shifting Through Enactment of Appropriate
Cost Containment Measures Applicable to All

Along with the extension of direct billing to all payors, ACLA's plan also calls for the establishment of payment caps on laboratory reimbursement from private payors, similar to the methodology that currently exists under Medicare. ACLA's proposal calls for these caps to be set at the actual median of the Medicare fee schedules, as defined in Section 1833(h) of the Social Security Act.

Enactment of such a provision would substantially lower reimbursement in the private sector. In addition, the combination of direct billing and fee caps would further ensure that the

benefits of price and service competition are enjoyed by the ultimate payor, either the patient or insurer. While it is impossible to calculate precisely how much such a provision would save, as competition could ultimately drive prices below this cap, ACLA expects the savings would be substantial.

The adoption of both of these measures together is a necessary predicate to the creation of a cost-conscious and efficient system.

2. Protect the Quality of Clinical Laboratory Testing

The second goal promoted by ACLA's health care reform plan is to protect and enhance the quality of laboratory testing. Congress has already taken the most important step towards ensuring quality, by enacting the Clinical Laboratory Improvement Amendments of 1988. This law required for the first time that all laboratories, regardless of site, would be subject to federal jurisdiction and assured that they would comply with appropriate, minimal quality assurance rules. Prior to the enactment of CLIA, the vast majority of laboratories were unregulated by federal or state law. Hearings held at the time demonstrated that unregulated laboratories often failed to hire the most qualified personnel, follow quality control procedures, or participate in proficiency testing. CLIA was passed to correct these problems. As a result, ACLA supports the implementation of CLIA and must oppose any substantial weakening of its standards.

3. Promote Simplification

The third goal of the ACLA plan is to promote simplification of the current system. The ACLA plan has two points to promote this goal in the laboratory industry: clarification of rules relating to profiles and administrative simplification.

a. Clarify the rules relating to test profiles

"Test profiles" are groups of related tests that are often ordered together. For example, a physician ordering tests for a patient with liver disease may order a "hepatic profile," a group of tests used for patients known or suspected to have this condition. While profiles are a necessary and valuable tool, the rules governing their ordering and billing have long been unclear.

Because of confusion in this area, ACLA has adopted guidelines, which we would be happy to share with the Members, to help ensure that physicians ordering profiles understand what they are ordering and what the financial consequences of their test-ordering decisions are likely to be. Even more needs to be done in this area, however. Currently, there is no uniform set of rules concerning what may be included in a particular profile, a circumstance that adds to the confusion. Therefore, ACLA's plan calls for the establishment of a process to govern the development and modification of standardized profiles with established test components. ACLA would be pleased to work with the Department of Health and Human Services and various medical societies in developing such a list.

b. Promote administrative simplification

Today, at least 33 different Medicare carriers have jurisdiction over laboratories providing testing to Medicare beneficiaries. Because laboratories often have testing facilities in more than one state, several different carriers, each with its own procedures and policies, usually have jurisdiction over a laboratory's operation. This system leads to confusion and unnecessary effort for all parties. As a result, the current system should be changed, so that laboratories could submit Medicare claims to a single carrier.

Further, the system should be clarified so that all providers understand what medical and insurance information must be obtained from each patient. This change would be especially important for laboratories, because they often do not have direct contact with the patient and have difficulty obtaining the required information if it is not provided initially by the physician.

Conclusion

ACLA is pleased to have this opportunity to testify before the Subcommittee today. We look forward to working with you in achieving the three goals of promoting a more efficient and cost-conscious system, protecting the quality of laboratory testing, and simplifying the system. We would be happy to answer any questions.

November 12, 1993

The Honorable Fortney "Pete" Stark
U.S. House of Representatives
Chairman, Subcommittee on Health
Committee on Ways & Means
239 Cannon House Office Building
Washington, DC 20515

Dear Representative Stark:

The undersigned groups represent a broad cross section of those involved in the provision of laboratory testing services. While we share a commitment to health care reform, we are writing to express our strong opposition to health care reform and budget proposals that target clinical laboratories for disproportionate and unfair reductions in Medicare reimbursement. The President's Health Security Act would reimpose laboratory coinsurance obligations on Medicare beneficiaries and would permit competitive bidding procurement of laboratory services for Medicare. Other bills, including the deficit reduction packages introduced by Congressmen Kasich and Penny and by Senators Kerrey and Brown, also mandate the reinstatement of laboratory coinsurance on beneficiaries.

As discussed below, these proposals would result in a significant cut in Medicare laboratory reimbursement. When added to reductions already mandated by OBRA '93, these provisions would constitute a total decrease of approximately 40 percent in Medicare payment to laboratories, even though laboratory payments only represent about 5 percent of total Medicare expenditures. Cuts of this magnitude will threaten the ability of laboratories to provide high quality services; to employ the most qualified individuals; and to ensure that all Medicare beneficiaries enjoy access to necessary laboratory services. As discussed below, each of these proposals would threaten the goals of health care reform.

Coinsurance

Because the amount of laboratory coinsurance on each claim is actually quite small -- often just a few dollars -- the cost of billing the copayment actually exceeds what is collected. Laboratory coinsurance is also difficult to collect, resulting in large bad-debt write-offs. As a result, some laboratories estimate that reenactment of coinsurance would constitute a cut in reimbursement to laboratories of at least 15 percent. Because of these concerns, when Congress adopted the current Medicare fee schedule methodology in 1984, it eliminated the coinsurance requirement with the approval of HCFA and the laboratory industry. Under this system, laboratories are required to accept assignment and cannot bill Medicare beneficiaries for covered services. This policy is reasonable because, unlike other forms of coinsurance, laboratory coinsurance does not affect utilization, a fact recognized by CBO in a 1990 report, because physicians, not patients, decide whether to order laboratory tests.

Competitive Bidding

Similarly, competitive bidding is also likely to have an adverse impact on laboratory services. In the past, Congress blocked implementation of a competitive bidding proposal offered by HCFA, because of concerns about its workability. The President's plan would create a "winner take all" competitive bidding plan for laboratory services that would have to lower expenditures by 10 percent per year, or other reductions in reimbursement would be triggered. Under this plan, only the winning laboratory would be able to supply Medicare services. Services supplied by other laboratories in the area would presumably be denied.

In the past when such laboratory competitive bidding systems were used by government and military programs, some providers submitted "low ball" bids to obtain the contract; however, they then could not afford to provide the services at the bid-winning price, quality was seriously compromised, and patients' health was put at risk. Moreover, requiring a minimum 10 percent reduction in expenditures is a wholly arbitrary standard that does not consider whether the reductions are reasonable or justified. Finally, such a competitive bidding system fails to recognize that laboratory services are a specialized, health care service; not a commodity. Physicians, therefore, often have strong preferences among laboratories because of quality and service differences. A competitive bidding plan such as that envisioned by the President's plan would remove the ability of physicians to choose the laboratory they believe best serves the needs of their patients.

Direct Billing

Laboratory providers do wish, however, to contribute positively to the health reform process. That is why members of the undersigned groups have supported measures to control laboratory costs and utilization, such as direct billing of laboratory services. Direct billing of all laboratory services, which would be mandated by S.337 introduced by Senators Jeff Bingaman and Howard Metzenbaum and by other health reform plans, would require that the laboratory that performs the testing also bill the patient or insurer for those services, rather than the physician who ordered the testing, as often happens today. Because the physician frequently marks up the price charged for the testing, the current system leads to increased utilization and higher laboratory costs. As a result, the federal government prohibits this mark up in the case of Medicare, but the practice continues with other payors. An independent study has shown that if the Medicare direct billing requirement were extended to all payors, it would reduce utilization of laboratory testing and lower costs, resulting in annual savings to the health care system of between \$2.4 and \$3.2 billion -- or between \$12 and \$16 billion over five years.

We strongly urge you to oppose the competitive bidding and coinsurance proposals currently being offered and hope you will support the enactment of a direct billing requirement.

Sincerely yours,

American Association for Clinical Chemistry
 American Association of Bioanalysts
 American Clinical Laboratory Association
 American Medical Technologists
 American Society for Clinical Laboratory Science
 American Society of Clinical Pathologists
 Clinical Laboratory Management Association
 College of American Pathologists
 International Society for Clinical Laboratory Technology
 Nichols Institute
 National Association for the Support of Long Term Care

Chairman STARK. Mr. Halamandaris.

**STATEMENT OF VAL J. HALAMANDARIS, PRESIDENT,
NATIONAL ASSOCIATION FOR HOME CARE**

Mr. HALAMANDARIS. Thank you, Mr. Chairman. It is a pleasure to be back before you. You run an excellent school and C-SPAN is providing a wonderful service by making it available to the American public. Since the last time I was before you, I have learned a lot and it is amazing how much more I have come to agree to your point of view.

I would like to say that we support the elements of the President's plan, but, like you, would like to see us build on the successes that we have achieved in the past. We are concerned about elements of the Medicare cuts in the President's plan. We agree with those Members of Congress who have said that it is very difficult to institute cuts of this magnitude without jeopardizing the integrity of the Medicare program, and we don't want to see that happen.

Another point that we would like to make for the record is that the President's plan would allow States to integrate into their systems the Medicare program, assuming that the services that were provided to Medicare beneficiaries were substantially equal to those that they are now receiving under Medicare. We would suggest that the States be barred, there be an absolute prohibition against the States being barred to integrate the Medicare program into their State plans until 2 years after the whole plan comes on-line. Only at that point can seniors exercise an informed choice about whether the new program is better or substantially better than or equal to the existing Medicare program.

There are several points we would like to make with respect to proposed Medicare cuts. One of them is that we take the President at his word. The President said we are trying to cut Medicare back to two times the rate of inflation. We can live with two X inflation but cannot live with three X.

What I would like to point out in a chart is that the home health industry is an excellent buy over the past 5 years. Costs have increased at only half the rate of inflation. Whereas inflation increased at 19.8 percent of the CPI, the cost of home care has increased at 8.1 percent.

In the same time frame from 1987 to 1991, we see hospital costs have soared 46.3 percent and medical services increased by 32.3 percent. If the President's rule is a good one, then we believe we should exempt any part of the health care industry that is increasing at less than the rate of inflation.

There have been significant increases in overall payouts in the Medicare program to home care. We would like to examine some of the reasons why.

First, more people are receiving services. There has been about a 30 percent increase in our payments to the Medicare home health industry and the number receiving services has increased by 27 percent. So there are more people who are receiving services.

You and other Members of the Congress have been very kind to the home care industry and the budget reconciliations have contained a modest increase in the Medicare home health entitlement

which made it available to more people. We have new technology which has come online and we have the effect of hospital DRGs with people being quicker and sicker and in need of home care services.

Another significant factor that has come about has been the significant effect of a lawsuit that was filed by the National Association for Home Care together with other provider and consumer organizations and that lawsuit entitled *Staggers v. Boeing* indicated that the Federal Government was illegally capriciously arbitrarily restricting the Medicare home health care benefit.

The lawsuit having come in on our side brought about a release of the floodgates and a significant increase in home care payments at one time. There were 17 Members of Congress who joined us as plaintiffs in that lawsuit as did other consumers and senior citizen groups that helped broaden the scope of the existing Medicare benefits.

Having said that, a couple of comments about copayments, in general. The Chairman I am sure is aware of these arguments. Our experience is that copayments cost more to collect than they save the program. Second, they fall heaviest on those who can least afford them. They also discourage transfers from hospitals.

One of the things we want to try to do is minimize the utilization of our most expensive facilities. We want to continue the progress toward reducing the institutional bias that the President and others have pointed out we have in our current health care system.

Finally, the copayments have a tendency to increase costs in other parts of the health system, most especially on the States that through the Medicaid program have to pick those costs up.

Mr. Chairman, we are troubled by some of the cuts that have been proposed by the administration. We would like to see us increase some of the funding that is available to help support health care. We think that alcohol and distilled spirits and those sin taxes need to be included, in addition to cigarettes. We understand some of the reasons why they would not, but there is a causal connection between those and significant health care problems.

We also would like to point out that the cost of providing home care services under the Medicare program is about \$65 a visit, but in the area of identical services given to private pay patients they can be delivered for approximately half of that cost. The reason is the administrative paperwork and the red tape associated with the NACare program, specifically the claims aspect. If we can go to one claim in terms of the President's new plan, or whatever plan the Congress approves, we certainly can go to one claim form and to electronic billing in the area of home care as well. Thank you.

Chairman STARK. Thank you.

[The prepared statement and attachments follow:]

TESTIMONY OF VAL J. HALAMANDARIS NATIONAL ASSOCIATION FOR HOME CARE

My name is Val Halamandaris. I am President of the National Association for Home Care (NAHC), which represents the nation's home care providers -- including home health agencies, home care aide organizations, and hospices -- and the individuals they serve. NAHC is committed to assuring the availability of humane, cost-effective, high quality home care services to all individuals who require them. Toward this end, NAHC has long advocated the development of a national plan to ensure universal access to basic acute care and long-term care services.

I am pleased to be here today to discuss President Clinton's health care reform proposal and its potential effect on the Medicare program. Before I begin, though, I want to commend Chairman Stark for the leadership he has demonstrated during the Committee's ambitious schedule of hearings on health care reform, and also to acknowledge the tremendous efforts he and the other members of the Committee have taken to protect the interests of Medicare beneficiaries and the Medicare program.

NAHC supports key elements of the Clinton health care reform proposal which are consistent with the top three priorities as established by the NAHC membership last year: (1) the plan preserves the Medicare program; (2) home care and hospice are a part of the acute care benefits package; and (3) the plan includes a new comprehensive long-term care benefit based on home care. With respect to the Medicare program, we are not only pleased that the plan will keep Medicare intact, but we are also supportive of the proposed Medicare prescription drug benefit which will include coverage of home infusion drug therapy. However, based on our review of the legislative language that President Clinton presented to Congress earlier this month, we have several concerns about the impact of the plan and some of its proposed financing mechanisms on the Medicare program.

Home Health Care Cost Limits

Although we understand that the Medicare reductions under this proposal would be used to fund health care reform rather than used for deficit reduction proposals, NAHC is still extremely concerned about the proposed reductions in the home health benefit. Specifically, NAHC is opposed to the proposed reduction in the home health cost limits from 112% of the mean to 100% of the median. This reduction would come on top of significant administrative cuts in the Medicare cost limits which the Health Care Financing Administration promulgated earlier this year, and a two-year freeze included in the fiscal year 1994 budget reconciliation act. It is estimated that over half of the Medicare-certified home health agencies will be adversely affected by the current cost limits by 1995. Switching to 100% of the median would bring an estimated, additional 15% reduction in the cost limits. Reducing the cost limits requires agencies to further reduce their costs in the very area where they have already exercised considerable restraint. From 1987 to 1991, for example, the cost-of-living or consumer price index (CPI) increased by 19.8%; physicians' and medical services increased by 32.2%; and hospital costs soared by 46.3%; however, home care costs increased by only 8.1% during the same period -- well under half the increase in the cost-of-living index.

The impact of the newly proposed cost limits, coupled with the previously mentioned administrative cuts and two-year freeze, will have a disproportionate, adverse effect on certain states. One of the most striking and unexpected findings from a September 1993 study conducted by NAHC is that the size of the cost limits' impact on a state tends to vary inversely with the use of home care services in the state. In other words, the states that use the fewest services are also the hardest hit by the cost limits, and it gets worse if you lower them. By 1995, Medicare beneficiaries in the one-third of the states hardest hit by the new cost limits will receive only a little more than half as many visits as beneficiaries in the states that are least affected. Cost limits reductions, like those envisioned in the Clinton plan, will clearly then only inhibit the ability of agencies to deliver, and beneficiaries to receive, vital, cost-effective home health care services.

Concerning the recent rise in home health costs under the Medicare program, it is important to keep in mind that the home health benefit has been a maturing program for most, perhaps all, of its existence in the Medicare program. In Medicare's earliest years of operation, home health expenditures amounted to only about 1% of the total. Therefore, although the benefit has increased at an average rate of 23% per year, it still represents a relatively small proportion of Medicare spending -- only about 6% of the total.

Congress intended growth in the Medicare home health benefit when it eliminated the home health deductibles and copays, eliminated the limits on visits and the prior hospitalization requirement, and broadened participation to include nonlicensed proprietary agencies. These amendments removed barriers to needed home health care and recognized the advantages of home health services over other acute care settings from the standpoints of patient preference and cost-effectiveness.

The home health benefit became especially useful in meeting the needs of patients who were discharged from the hospital "quicker and sicker" as a result of the 1983 enactment of the Medicare hospital prospective payment legislation. The percent of all Medicare hospital patients discharged to home health care increased to 18% compared to only 9% in 1981. Technological advances have also done much to make the home a safe and effective acute care setting. These factors together with the aging of the population, the increased paperwork burden, and an increased public and professional awareness of home health care have all contributed to the home health benefits' rapid increase over the past 25 years.

Estimates from the Health Care Financing Administration's Office of the Actuary indicate that the benefit has matured and that expenditure increases will fall to 8.5% by 1998. Even as the acute care benefit matures, new home care growth would occur as a result of comprehensive reform of the U.S. health care system or development of a federal long-term care program.

The home health benefit increases that have occurred in the 1989-1992 period are almost double the 23% average experienced over the life of the Medicare program. As indicated above, we believe this peaking is temporary and that it is occurring for the following reasons:

1. Sporkin decision -- In the mid-1980s, Medicare adopted documentation and claims processing practices that created general uncertainty among agencies about what services would be reimbursed. The result was a so-called "chilling effect" in which some Medicare-covered claims were diverted to Medicaid and regrettably some patients went without care. This "denial crisis" led in 1987 to a lawsuit brought by a coalition led by Representatives Staggers and Pepper, consumer groups and NAHC. The successful conclusion of this suit gave NAHC the opportunity to participate in a rewrite of the Medicare home health payment policies. Just as a lack of clarity and arbitrariness had depressed growth rates in the preceding years, we believe that policy clarifications that resulted from the court case have allowed the program for the first time to provide beneficiaries the level and type of services that Congress intended. The correlation between the policy clarifications and the increase in visits is unmistakable: the first upturn in visits (25%) came in 1989 when the clarifications were announced; and an even larger increase (50%) took place in 1990, the first full year the new policies were in effect.

Attached is a copy of the Washington Post article on the Sporkin decision. (Attachment 1).

2. Personnel shortage -- Throughout much of the 1980s, the home care industry, along with the rest of health care, was suffering from a personnel shortage. Although there are still acute shortages of certain disciplines, it would appear that conditions have substantially improved. This increase in available staff allowed the number of certified home health agencies to increase from 5,676 in 1989 to nearly 6,500 in 1993.

3. New legislative requirements -- In the past five years, the home health program has seen the addition of several costly legislative changes, including the OBRA-87 home health aide training and competency

testing requirements and the Clinical Laboratory Improvement Amendments of 1988. The costs associated with these changes are reflected in visit charges.

4. New administrative changes -- The 1992 OSHA mandate regarding employee protection from transmission of HIV and Hepatitis B, including employee vaccinations, is a cost that must be borne by employers.

5. Increased awareness -- The past decade has seen dramatic increases in awareness among physicians and patients about the home as an appropriate, safe and often cost-effective setting for the delivery of health care services. For example, a 1985 survey found that only 38% of Americans knew about home care; by 1988, over 90% of the public not only understood home care to be an appropriate method of delivering health care, but also supported its expansion to cover long-term care services as well. A new poll conducted in 1992 by Lou Harris and Associates found that the American public supports home care by a margin of 9 to 1 over institutional care. Nearly 82% of all accredited medical schools now offer home health care in their curricula.

Attached to this testimony is a chart which shows that, from 1987 to 1991, home health costs have increased at a far slower rate than the CPI and other health care costs. (Attachment 2).

Home Health Care Copayments

Another area of concern to NAHC centers on the Clinton Administration's intention to impose a 10% copayment on Medicare home health services. For several reasons, we oppose such a regressive and inefficient proposal.

First and foremost, a 10% copayment for home health services will hardest hit the poorest and oldest Medicare beneficiaries. For many beneficiaries, the \$8.3 billion in savings the proposal projects for the Medicare program will translate into copayments of several hundred dollars a year. Home health care recipients are older and have even fewer financial resources than the general Medicare population. Individuals over age 75 account for less than half of the total Medicare population, but comprise nearly three-fourths of the home health beneficiaries. A copayment for home health services, therefore, would fall most heavily on the oldest group of Medicare beneficiaries. In fact, while individuals over age 85 bear 12% of the total revenues raised by the Part B copayment, they would be responsible for 25% of the revenues raised by the home health copayment.

The elderly are already health-care poor without this added new expense. Seniors spend nearly twice as much of their income on health care as they did before Medicare began (10.6% in 1961 compared to 17.1% in 1991). And 12.2% of the elderly now live below the federal poverty level. In addition, nearly three-fourths of the poor elderly do not own Medigap insurance to help cover the costs of copayments. Even the Medicaid and Qualified Medicare Beneficiary (QMB) programs provide inadequate protection from these costs. In 1990, less than a third of the elderly poor received Medicaid assistance and fewer than half of those eligible for the QMB program -- a program designed to help poor seniors avoid the substantial out-of-pocket costs related to Medicare -- received the benefit.

We also oppose home health care copayments because copayments are notoriously inefficient. In particular, the collection of copayment amounts would create unnecessary paperwork. Many home health patients receive only a few visits (29% received fewer than 10 visits in 1991). However, agencies would have to set up billing and tracking programs for even these relatively small amounts.

Finally, we believe that a copayment requirement for home health would exacerbate the institutional bias inherent in the Medicare program by creating strong disincentives to use home health services. Home health was exempted from the Part B coinsurance in 1972 in order to encourage utilization of less costly non-institutional services. Reimposing a coinsurance would dramatically undermine that effort and create strong financial incentives for institutional care. Thus, for all of these

reasons, we ask that the Administration and Congress work together to determine a more equitable and efficient mechanism for financing needed Medicare and long-term home care benefit expansions.

Preservation of Medicare

NAHC strongly endorses the Administration's decision to keep the Medicare program intact. Medicare has proven to be an overall effective program that through the years has been tailored to meet the special needs of our nation's most medically and economically vulnerable citizens. More importantly, the program represents a covenant with the American people that should not be broken by the Federal government. However, there are purely practical reasons for preserving Medicare as well.

First, Medicare has already resolved some of the major problems that we are seeking to remedy through health care reform. Medicare beneficiaries, for example, have access to affordable care, and the costs of financing care for Medicare patients is equitably distributed. This is in stark contrast to the current system where the uninsured receive inadequate care at the expense of the insured.

Medicare is also a popular program. As evidence, in areas of the country where beneficiaries were given the choice of either staying in Medicare or enrolling in another alternative delivery system, only 5% chose to enroll in a health maintenance organization. Clearly, the current Medicare-coordinated care strategies that are available to Medicare beneficiaries have not attracted many beneficiaries.

Another reason the Medicare program should be kept intact is because it is a tried and tested program. For all of the effort and thought that has gone into drafting the Clinton health care reform proposal, it is still a risky venture. Implementation of a new health care reform proposal that will substantially alter one-seventh of the American economy is bound to at least temporarily disrupt the continuity of care for certain populations. At least by allowing the 34 million Medicare beneficiaries to remain in the Medicare program, the Administration's difficult task of implementation will be lessened. Further, Medicare beneficiaries, some of our nation's most fragile citizens, will be spared the pains of what could be an arduous transition.

Of course, NAHC is concerned about a provision of the President's plan that would allow the states to enroll Medicare beneficiaries into an alternative plan, so long as the states could prove that the benefits would be equal or superior to those offered under Medicare.

My experience with Medicaid, the deinstitutionalization of the mentally ill, and other state initiatives leads me to conclude that while such a diversion to a state plan might appear to be initially attractive, any proposal that could force the elderly to surrender their federal Medicare entitlement could ultimately prove to be a poor exchange.

While we strongly endorse the Administration's decision to keep the Medicare program intact, we clearly have some concerns regarding certain provisions of the Clinton Health Security Act and the impact that these provisions could have on the status of the Medicare program. We know that Members of Congress share many of our concerns and we look forward to working with the Congress, as well as the Administration, to ensure that Medicare beneficiaries will also reap the benefits of health care reform.

Medicare Change Illegal, Judge Says

Many Denied Home Care Benefits Under 'Drastic' New Policy

By Lee Hockstader
Washington Post Staff Writer

A federal judge here has ruled that the Reagan administration illegally blocked hundreds and perhaps thousands of elderly and disabled people from receiving Medicare benefits, and ordered the government to correct the "abuses" within 30 days.

In a decision made public yesterday, U.S. District Court Judge Stanley Sporkin said the administration effected a "drastic" and "arbitrary" change in policy when it decided that Medicare would not reimburse people who received more than four home visits a week from nurses or health aides.

The policy, he wrote, has "a devastating impact" on elderly or ailing people who are unable to appeal.

"Because [the government is] unwilling to provide part-time daily home health services, many people needlessly have been forced to make the cruel choice between foregoing needed care or submitting to institutionalization in a nursing home or hospital," he said.

The judge also certified the case as a class-action suit, meaning that the government must reopen all Medicare claims from people whose benefits were denied because of the administration's policy shift.

Medicare, a health insurance system for the aged and disabled established by Congress in 1965, for years met the cost of nursing care, therapy and other health services rendered at home—as long as the services were not full time. In 1986, about 1.6 million people submitted claims for such home-care benefits.

The home-care program was designed to provide services at home for people who are not so disabled that they need to be hospitalized or confined to a nursing home. Proponents contended that the program ultimately saves money for the government by easing the burden on hospitals and nursing homes.

Under the Reagan administration, however, the Health Care Financing Administration (HCFA), which administers the Medicare system, tightened eligibility requirements. The new guidelines—never published—barred reim-

bursements to people who needed care more than four days a week.

The change resulted in benefits being cut off to people who, for example, required nursing care for one hour a day, five days a week, while preserving the reimbursement for those who needed five hours of care four days a week, Sporkin said.

Individuals who received home nursing services more than four days a week were denied not merely Medicare coverage for care in excess of four days, but received no reimbursement for any home visits, Sporkin wrote.

"The [government's] rigid and narrow definition . . . is inconsistent with the agency's longstanding interpretation of the home health care benefit and contrary to law and congressional intent," his opinion said.

Sporkin's ruling came in response to a lawsuit filed last year by 17 elderly Medicare recipients, several home health care agencies, the National Association for Home Care and about a dozen members of Congress.

William A. Dombi, director of the National Association of Home Care's



JUDGE STANLEY SPORKIN
... policy had "devastating impact"

Center for Health Care Law, said the judge's decision signaled the restoration of a promise made by Congress in 1965 but broken by the Reagan administration to save money.

"The government was trying to create a law as they wish it had been," he said. "In the future, individuals will have a chance to receive benefits based on a proper definition of the law."

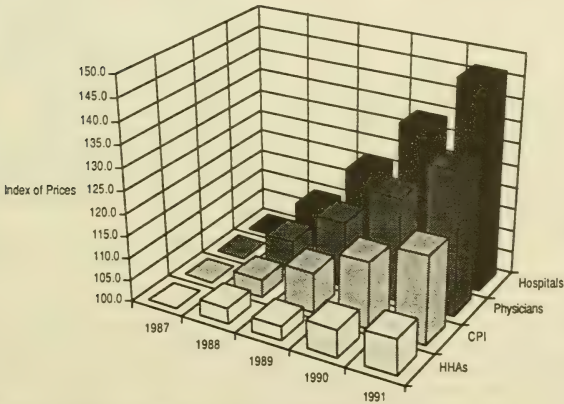
Bob Hardy, spokesman for the HCFA, said that while the agency had not had a chance to review Sporkin's opinion, "We believe we are properly administering the home health care benefit."

ATTACHMENT 1

Home care agencies should be exempt from Medicare cuts in any form: data show that home care is a "good buy."

Data collected from various sources and analysed by the National Association for Home Care (NAHC) show that, from 1987 to 1991, the cost of living or consumer price index (CPI) increased by 19.8%, the cost of physicians' and medical services increased by 32.2%, and hospital costs soared by 46.3%. By contrast, home care costs increased by only 8.1% during the same period—well under half the increase in the CPI, and far below the average at which health care costs have been increasing.

Consumer Price Index Compared With Prices for Home Care, Hospital, and Physician Services, 1987–1991



Source: The National Association for Home Care Research Department

Chairman STARK. Mr. Zawiski.

STATEMENT OF MARK ZAWISKI, SOUTHEAST REGIONAL DIRECTOR, NATIONAL RENAL ADMINISTRATORS ASSOCIATION, AND ADMINISTRATOR AND CHIEF EXECUTIVE OFFICER, INTER-AMERICAN DIALYSIS INSTITUTE

Mr. ZAWISKI. Good afternoon, Mr. Chairman. I am Mark Zawiski, the administrator and chief executive officer of Inter-American Dialysis Institute, which operates three outpatient dialysis facilities in Miami, Fla. I am currently the southeast regional director of the National Renal Administrators Association.

The NRAA is a voluntary organization representing professional managers of dialysis facilities and centers throughout the United States. Our members manage approximately two-thirds of the dialysis units in this country which provide dialysis services to a majority of Medicare ESRD patients.

We appreciate the opportunity to appear before the subcommittee to discuss ESRD-related budget issues. Our testimony will focus on two recommendations related to the Medicare end stage renal disease program. One, we strongly recommend the subcommittee review and approve the Prospective Payment Assessment Commission's recommendation number 18 of their March 1993 Report and Recommendations to Congress, which called for a 2.5 percent update to the composite rate for dialysis treatment services for 1994.

Number two, with regard to health care reform, we earnestly request that the subcommittee include renal-related medical services and transplantation in any standard or comprehensive benefits package that must be offered by all health plans.

Further, that until a fully implemented universal health care system is in place, that the Congress maintain Medicare's ESRD program as it is currently structured.

Medicare's payment structure for dialysis facilities is unique in the Medicare system. Dialysis facilities are paid a prospective payment to cover the costs of providing all dialysis-related services. This prospective payment system has been called the first DRG. However, unlike hospital DRG payments which are annually updated, there is no statutory automatic update to the ESRD composite rate payment as there are for hospitals, hospices, nursing homes, and other health care providers. Instead, payments to dialysis facilities can only be increased by Congress or the administration.

We were relieved to not have seen a decrease in dialysis treatment reimbursement included in the proposed \$124 billion in Medicare savings in the President's Health Security Act. However, as the administration is quick to point out, the provider savings in the President's bill are reductions in the rate of growth of provider payments. For dialysis facilities, as there is no update to reduce, when there is no increase in facility payments, it is actually equivalent to a cut in reimbursement.

An update is long overdue. For 20 years, the Federal Government has essentially frozen the level of payments to dialysis facilities. The initial reimbursement rates for outpatient dialysis were established in 1973 and remained unchanged until 1983. The rates

were lowered in 1983 and again in 1986. During this time, no adjustments were made for inflation.

Mr. Chairman, thanks in large part to your efforts dialysis payments were increased by \$1 per treatment in 1991. However, adjusting for inflation, dialysis rates were nearly 65 percent lower in 1991 than they were in 1974, according to this committee's own 1993 Green Book.

You may recall, Mr. Chairman, that you spoke before our annual meeting in Washington in 1990 and at that time you had hoped to be able to increase payments for dialysis treatments by \$3 or \$4. At this time, we hope that you will continue to support your original pledge to that commitment.

To continue the reimbursement at the current rate will not allow the ESRD community to make needed changes. While no study has been able to conclusively link quality and cost, the Institute of Medicine, in its report entitled *Kidney Failure and the Federal Government*, has concluded that previous decreases in reimbursement may have adversely affected quality. The IOM recommended that Congress update dialysis facility payments yearly. This report was published in 1991 and the recommendation to date has not been acted upon.

There are several reasons why dialysis reimbursement must be increased. First, we would like to remind the subcommittee that no other medical providers have been forced to live without inflationary updates like dialysis providers. Second, no other medical provider has less opportunity to cost shift than dialysis providers, given that on average 90 percent of our reimbursement is derived directly from the Medicare program. Also, the possibilities to cost shift to the private payers have been reduced in recent years as more patients are enrolled in managed care that pay close to or at the Medicare allowable rates.

Third, productivity gains of the past cannot be replicated in the 1990s. Fourth, we cannot lower our staff to patient ratios any further. Fifth, nor can we continue to reduce the ratio of registered nurses to nonregistered clinical staff we use in our clinics. Sixth, all of the gains from reprocessing dialysis filters have already been achieved. We are now caring for a patient population that has been on dialysis for over 20 years and they have more comorbid conditions which require more labor-intensive care. We are seeing patients being discharged from hospitals in less stable conditions which also serves to increase the time dialysis facility staff must spend with these patients and, hence, our costs.

Lastly, there have been several recent recommendations to establish a new adequacy of dialysis treatment standard, what we call a Kt over V equal to 1.2 for hemodialysis to improve mortality and morbidity rates. While this new standard should produce financial efficiencies as patients live longer, for the immediate future this new standard will serve to further increase costs for many dialysis facilities. Some facilities will have to spend considerable capital outlays to purchase more high-tech dialysis machines. Other providers will see increased costs as they will have to dialyze patients longer than they currently do.

By all accounts, in real dollars, payment rates for dialysis have fallen steadily over the program's history. While we will be the first

to admit that during the 1970s and 1980s some operating costs decreased and the industry achieved some impressive productivity gains, in the 1990s we face a very different picture as both the 1991 IOM report and the ProPAC 1993 Report to Congress point out. Both have recommended increasing Medicare payments to dialysis facilities.

Mr. Chairman, I am sure that it will come as no surprise to you and the other members of this committee that the association wholeheartedly endorses ProPAC's recommendations in their 1993 report to Congress. Other organizations within the ESRD community have also embraced ProPAC's recommendation. We believe the ProPAC recommendation is less than adequate based on our own analysis of ProPAC's average cost data trended forward and modified to include some additional costs for new regulatory requirements which were not part of their original analysis.

We believe that dialysis costs in 1994 will be higher than ProPAC has projected and therefore a larger percentage update could be justified. However, we do recognize the cost constraints the subcommittee will be in in the coming years. Given this fact, we strongly encourage the subcommittee to support ProPAC's 2.5 percent increase in payments for freestanding and hospital-based dialysis facilities.

We also understand that the administration's Health Security Act includes dialysis services and transplantation as covered services that all alliance health plans will have to offer. Currently Medicare covers approximately 93 percent of the ESRD population. However, according to the earlier-referenced 1991 Institute of Medicine study, a growing number of ESRD patients are not eligible for the Medicare benefit. Therefore, we believe there is an absolute need for ESRD treatments to be included in any health care reform benefits package.

Mr. Chairman, we again want to thank you for the opportunity to testify before this subcommittee. We strongly endorse ProPAC's recommendation to increase payments.

As individuals responsible for financial management of dialysis facilities, we sincerely believe that an update is necessary in order to cover our increasing costs and make it possible for us to continue providing quality care for our patients. I will be pleased to answer any questions you may have.

[The prepared statement follows:]

TESTIMONY OF MARK ZAWISKI NATIONAL RENAL ADMINISTRATORS ASSOCIATION

Good afternoon Mr. Chairman and Members of the Subcommittee. My name is Mark Zawiski, and I am the Administrator, CEO of Inter-American Dialysis Institute, which operates three out-patient dialysis facilities in Miami, Florida. I am currently the Southeast Regional Director of the National Renal Administrators Association (NRAA).

The NRAA is a voluntary organization representing professional managers of dialysis facilities and centers throughout the United States. Our members manage approximately two-thirds of the dialysis units in this country which provide dialysis services to a majority of Medicare End-Stage Renal Disease (ESRD) patients. The association was founded to provide information and education to our members and to work with Congress, the Administration and other oversight organizations on the Medicare ESRD program.

We appreciate the opportunity to appear before the Subcommittee to discuss ESRD related budget issues. Our testimony will focus on two recommendations related to the Medicare ESRD program:

1. We strongly recommend the Subcommittee review and approve the Prospective Payment Assessment Commission's recommendation 18, of their **March 1993 Report and Recommendations to Congress**, which called for a 2.5% update to the composite rate for dialysis services in 1994.

2. With regard to health care reform, we earnestly request that the Subcommittee include renal related medical services and transplantation in any "standard" or "comprehensive" benefits package that must be offered by all health plans. Further, that until a fully implemented universal health care system is in place the Congress maintain Medicare's ESRD program as it is currently structured.

NO INCREASE IN REIMBURSEMENT EQUALS A DECREASE

Medicare's payment structure for dialysis facilities is unique in the Medicare system. Dialysis facilities are paid a prospective payment to cover the costs of providing all dialysis related services. This prospective payment system has been called the first DRG. However, unlike hospital DRG payments which are annually updated, there is no statutory automatic update to this payment, as there are for hospitals, hospices, nursing homes and other providers. Instead, payments to dialysis facilities can only be increased by the Congress or the Administration.

We were relieved to have not seen a decrease in dialysis treatment reimbursement included in the \$56 billion in Medicare cuts in the Omnibus Budget Reconciliation Act of 1993 (OBRA '93) and were equally relieved that the proposed \$124 billion in Medicare savings in the President's Health Security Act does not include a provision to reduce payments to dialysis facilities. However, as the Administration is quick to point out the provider savings in the President's bill are reductions in the rate of growth in the provider payments. For dialysis facilities, as there is no update to reduce, when there is no increase in facility payments it is actually equivalent to a cut in reimbursement.

REASONS TO SUPPORT AN INCREASE

An update is long overdue. For twenty years the Federal government has essentially frozen the level of payments to dialysis facilities. The initial reimbursement rates for out-patient dialysis were established in 1973 and remained unchanged until 1983. The rates were lowered again in 1983 and again in 1986. During this time, no adjustments was made for inflation.

Mr. Chairman, thanks in large part to your efforts dialysis payments were increased by \$1 per treatment in 1991. However, adjusting for inflation, dialysis rates were nearly 65% lower in 1991 than they were in 1974, according to this committee's own 1993 Green Book.

You may recall, Mr. Chairman, that you spoke before our annual meeting in Washington in 1990, and at that time you had hoped to be able to increase payments by \$3 or

\$4 per treatment. At this time we hope that you will continue to support your original pledge to that commitment.

To continue the reimbursement at the current rate will not allow the ESRD community to make needed changes. While no study has been able to conclusively link quality and cost, the Institute of Medicine (IOM), in its report entitled **Kidney Failure and the Federal Government**, has concluded that "previous decreases in reimbursement may have adversely affected quality." The IOM recommended that Congress update dialysis facility payment rates yearly. This report was published in 1991 and their recommendation to date has not been acted upon.

There are several reasons why dialysis reimbursement must be increased. First, we would like to remind the Subcommittee that no other medical providers have been forced to live without inflationary updates like dialysis providers. Second, no other medical provider has less opportunity to cost shift than dialysis providers given that on average 90% of reimbursement is derived from Medicare. Also, that the possibilities to cost shift to private payers have been reduced in recent years as more patients are enrolled in managed care plans that pay close to the Medicare rate. Third, the productivity gains of the past cannot be replicated in the 1990s. Fourth, we cannot lower our staff to patient ratios any further. Fifth, nor can we continue to reduce the ratio of registered nurses to non-registered nurse staff. Sixth, all of the gains from reprocessing dialyzers have been achieved.

Seventh, we are now caring for a patient population that has been on dialysis for twenty years and they now have more co-morbid conditions which require more labor intensive care. We are seeing patients being discharged from hospitals in less stable conditions which increases the time dialysis facility staff must spend with these patients.

Lastly, there have been several recent recommendations to establish new adequacy of dialysis treatment standards in order to improve mortality and morbidity rates. For example, the National Institutes of Health Consensus Conference held November 1-3, 1993 has recommended a new adequacy of dialysis standard of 1.2 Kt/Vd. The Renal Physicians Association has also recommended this standard in their practice guidelines. While this new standard should ultimately produce financial efficiencies as patients live longer, for the immediate future this new standard will serve to increase costs for many dialysis facilities. Some facilities will have to spend considerable capital outlays to purchase more "high-tech" dialysis machines. Other providers will see increased costs as they will have to dialyze patients longer than they currently do.

By all accounts, in real dollars, payment rates per dialysis have fallen steadily over the program's history. While we will be the first to admit that during the 1970s and 1980s some operating costs decreased and the industry achieved some impressive productivity gains, in the 1990s we face a very different picture as both the 1991 IOM Report and the Prospective Payment Assessment Commission 1993 Report to Congress point out. Both have recommended increasing Medicare's payments to dialysis facilities.

ENDORSEMENT OF PROPAC 2.5% UPDATE RECOMMENDATION

Mr. Chairman, I am sure that it will come as no surprise to you and the other members of the committee that this association whole-heartedly endorses ProPAC's recommendation in their 1993 Report to Congress that both free-standing and hospital-based dialysis facilities receive a 2.5% update in their 1994 composite rate payments.

Other organizations within the ESRD community have also embraced ProPAC's recommendation. On March 18, 1993 Dr. Peter Lundin, the then President of the American Association of Kidney Patients testified to this committee and said "... it is also clear that reimbursement levels for ESRD in recent years have been implicated in the decline of quality care." Dr. Lundin further testified that, "we urge the Subcommittee therefore to carefully consider the current circumstances and provide an appropriate rate of increase for dialysis

services which will enable facilities to provide cost-effective high quality care."

We believe that ProPAC's recommendation is actually less than adequate. This is based on our analysis of ProPAC's average cost data trended forward and modified to include some additional costs for new regulatory requirements which were not part of their original analysis. However, knowing full well the medical cost constrained environment which we are facing, we believe that a 2.5% update to the composite rate would be a reasonable compromise. Along with the AAKP and ProPAC we truly believe that this increase is vitally necessary to maintain quality of care in dialysis facilities.

PROPAC FORMULA FOR UPDATING DIALYSIS PAYMENTS

Because we support ProPAC's recommendation we would like to briefly review how they arrived at this recommendation. Using a formula similar to the one used to calculate the hospital payment update, ProPAC determined that dialysis services should receive a 2.5% update for hospital-based and free-standing facilities in FY 1994.

To determine this recommendation, ProPAC calculated that a "market basket" of the goods and services providers purchase to furnish dialysis services is projected to increase in FY 1994 by 4.5%.

ProPAC also determined that new technologies will increase the cost per dialysis treatment by 1% in FY 1994. We believe that this may be understated as many dialysis facilities are now faced with the need to replace older equipment with more technologically advanced high flux and high efficiency hemodialysis machines, (which cost between \$14,000 and \$18,000 versus \$8,000-\$9,000 for conventional machines) as well as, provide upgrades to their physical plant. While the new machines initially lowered treatment times, now treatment sessions have become both more-capital and supply-intensive, resulting in significant increases in costs per treatment.

To further measure changes in projected costs ProPAC looked at future changes in costs attributable to improvements in productivity. Based on a Project HOPE study they concluded that the "marked productivity gains experienced in the dialysis industry through 1987 are not likely to continue." Instead, "scientific and technological advances have changed the nature of dialysis services such that only modest improvements in productivity are expected."

Realistically, the commission concluded that dialysis facilities can expect only a 2% increase in productivity in FY 1994. They believe the savings from increased productivity should be shared equally by the industry and Medicare, resulting in a productivity adjustment of 1%.

Using their own formula they should have arrived at a 4.5% recommendation (i.e. market basket 4.5% + science and technology 1% - productivity - 1% = 4.5%). However, they decided to further reduce the update recommendation by 2% as a "discretionary adjustment," primarily because of ProPAC's lack of confidence in HCFA's data. This is one area in which we would disagree with their analysis.

NRAA COST ANALYSIS

Our own analysis of cost report data and projections indicate that the projected mean blended 1994 cost per dialysis (82% hemodialysis and 18% continuous ambulatory peritoneal dialysis) will be \$125.44. To arrive at the 1994 projected cost per dialysis we used ProPAC's average annual percentage change from 1989 through 1991. When adjusted for both the additional cost of 5.1% (which ProPAC has accepted) due to the misallocation of overhead costs attributed to Erythropoietin (EPO) on the cost report, and an average additional \$3.45 for costs associated with new regulatory requirements, we conclude that the actual mean blended cost for free-standing facilities in 1994 will be \$135.13. By contrast, median payments are \$126 for free-standing facilities and \$130 for hospital-based facilities.

Having said this, we also firmly believe that misallocation of costs on the cost reports and the disallowance of legitimate costs of doing business distort the true costs of providing dialysis services as reported by HCFA. For example, as we have indicated above if administrative and general expenses were properly allocated away from EPO the cost of dialysis would be higher than currently shown by 5.1%. HCFA has even acknowledged this and is changing the cost report form to more properly allocate the administrative and general expenses to the dialysis side and away from the EPO side of the cost report. Also, if some true costs of providing dialysis services were allowed on the cost reports we again firmly believe the real reported costs of dialysis services would be further increased.

There are also many costs which have only recently been incurred by dialysis facilities that are not part of the costs reported in the 1989 - 1990 data, which ProPAC used for their analysis. Some of these costs include:

- (1) Regulatory changes, such as the OSHA Bloodborne Pathogen Regulation and the Clinical Laboratory Improvement Act (CLIA) which will increase monitoring and testing costs for all out-patient facilities performing Activated Clotting Tests (ACTs);
- (2) Increased cost for the disposal of biomedical waste under state laws. As a result of the Florida biomedical waste law, it now costs my facilities between \$1.25 and \$1.50 per treatment for the handling, packaging and transporting of these wastes.
- (3) State nursing practice act changes which are causing increased requirements for licensed staff as opposed to unlicensed patient care technicians. Registered nurse salaries in the industrialized states of NY, CA and Florida average between \$16 and \$25 per hour versus technician salaries of between \$7 and \$12 per hour, depending on experience and duties performed.
- (4) Increased costs associated with the recapitalization of dialysis facilities for new high flux/high efficiency dialysis equipment which cost on average between \$14,000 and \$18,000 versus \$8,000 to \$9,000 for conventional machines; and
- (5) Increased disposable supply costs for high flux/high efficiency dialyzers.

Our studies indicate that regulatory compliance costs associated with numbers 1 and 2 will add approximately \$3.45 per dialysis treatment.

Salary and benefit costs have also increased significantly over the past few years. An NRAA analysis of cost reports for 1989-1991 indicates that free-standing and hospital-based facilities aggregate hemodialysis and peritoneal dialysis salary costs increased more than 13%. These costs represent about 50% of the cost of providing dialysis services. Dialysis facilities must offer attractive salaries and health benefits in order to compete with hospitals for the most qualified nursing staff. Many free-standing dialysis facilities are facing the same problems with rising health insurance costs that other small businesses are facing.

We will also point out that our calculations do not take into account an adjustment for the fact that the cost reports used in the ProPAC analysis have not been audited. While we do not know what adjustment should be made, we believe HCFA's 11.8% downward adjustment, which ProPAC has decided to adopt, is too high. We are currently researching and evaluating what an appropriate audit adjustment, if any, would be.

In short, we believe that dialysis costs in 1994 will be higher than ProPAC has projected and therefore a larger percentage update could be justified. However, we recognize the cost constraints the Subcommittee will be under in the coming years. Given this fact we strongly encourage the Subcommittee to support ProPAC's 2.5% increase in payments to both free-standing and hospital-based dialysis facilities for FY 1995.

HEALTH CARE REFORM

It is our understanding that a component of health care reform will be the development of a standard or comprehensive benefit package that all plans or employers will have to provide. We also understand that the Administration's Health Security Act includes dialysis services and transplantation as covered services that all alliance health plans will have to offer.

Currently Medicare covers approximately 93% of the ESRD population. However, according to the earlier referenced 1991 Institute of Medicine Study a growing number of ESRD patients are not eligible for the Medicare benefit. This study points out that the "absolute number of such patients has been growing and substantial variation exists among states and major cities." They go on to say that the major non-Medicare sources for financing ESRD treatment are not adequate to meet the need of the unentitled patients. The Department of Veterans Affairs dialysis program is shrinking; the Indian Health Service faces many other demands on its limited resources; and in 19 of the 20 states that do have a state kidney disease program benefits vary and budgets are not increasing. Thirty one states have no kidney disease programs at all. With respect to Medicaid, the report further states, "although Medicaid ESRD benefits appear to be adequate in many states, in others, they are not, as eligibility criteria and covered benefits vary widely according to state discretion." For example, in Florida there are no primary payments for dialysis services for Medicaid patients.

Mr. Chairman, given the above we believe there is an absolute need for ESRD treatments to be included in any health care reform benefits package. Therefore, we strongly recommend that all medically necessary renal related care be a covered benefit in whatever health care reform is eventually adopted.

The NRAA and all of the members of the renal coalition (American Association of Kidney Patients, American Nephrology Nurses' Association, National Kidney Foundation, Renal Physicians Association, and National Association of Nephrology Technologists) also strongly urge that the Medicare ESRD program not be restructured as part of health care reform. We agree with John K. Iglehart who in a recent health policy report regarding the ESRD program published in the *New England Journal of Medicine* (February 4, 1993) stated, "As they consider broader reform of our troubled health care system, Congress and the Clinton Administration would do well to examine the history of the ESRD program more closely, because it demonstrates how the government, as a virtual single payor, can tightly constrain per patient costs. At the same time it shows how facilities and physicians can weather such constraints and still deliver care to patients whose very lives depend upon it, ..."

Medicare's ESRD program has been enormously effective in terms of quality care, the number of lives saved and the increased life expectancy. Further review of health care reforms currently under discussion have created deep concern over how dialysis patients and dialysis providers will fair under health care reform. We believe that the ESRD program should be studied carefully before any changes are recommended. Certainly once health care reform is enacted and operative we would expect the Medicare ESRD program to be reevaluated for possible restructuring. But for now we would not want to see changes made that could in any way effect the current access kidney patients have to a first rate system of medical benefits.

CONCLUSION

Mr. Chairman, we again want to thank you for the opportunity to testify before the Subcommittee today. We strongly endorse ProPAC's recommendation to increase payments to both free-standing and hospital-based dialysis facilities by 2.5% in FY 1995. As the individuals responsible for the financial management of dialysis facilities, we sincerely believe that an update is necessary in order to cover our increasing costs and make it possible for us to continue providing quality care to our patients.

At this time I would be pleased to answer any questions that you may have.

Chairman STARK. Dr. Willging.

**STATEMENT OF PAUL WILLGING, PH.D., EXECUTIVE VICE
PRESIDENT, AMERICAN HEALTH CARE ASSOCIATION**

Mr. WILLGING. Thank you, Mr. Chairman. You have been commended for your tenacity. I am equally impressed with your endurance.

Thank you for the opportunity to speak to the issue of the proposed Medicare cuts in the President's health reform proposal. I think the President is to be commended for beginning to focus attention in this country on the critical issue of health care reform. I am less likely to commend the President, however, for proposing to subsidize or to fund his proposal on the backs of the most vulnerable of our population, the elderly and the poor.

It has been said that these were not really cuts but these simply are attempts to restrain the rate of growth. I would contend that they are indeed cuts. Particularly with respect to nursing facilities, Mr. Chairman, these are cuts on top of a system which already does a notoriously poor job obtaining the reasonable costs for health care providers.

Currently one-quarter of nursing facilities in the Medicare program hit the caps, the routine cost limits and essentially don't have their costs above those limits paid for. Under the President's proposal that percentage would grow to 59. Six out of 10 Medicare nursing facilities would not have their costs reimbursed. Currently only 93 percent of costs in the Medicare program are reimbursed for nursing facilities. Under the President's proposal, that would drop to 83 percent.

You commented to the previous panel that in fact the Medicare program at least has not achieved the dubious distinction of paying less than the Medicaid program. With the President's proposal, the Medicare program would, in fact, achieve the dubious distinction of paying less of reasonable costs than even paid by the Medicaid program in the various State programs. Currently the average cost for a day of care in a nursing facility is \$88. The Medicaid program pays \$77, 88 percent of the costs. The proposal by the President would drop the Medicare percentage of costs reimbursed down to 83 percent.

Everyone talks about that in fact being the case. In fact, there are few health care providers dependent upon the Medicare program who do have their full costs reimbursed. The program has become notorious for that fact. We are, unfortunately, in the disadvantageous position of having, however, the vast majority of our residents supported by government programs.

Seventy-five to 80 percent of all residents in nursing facilities are covered by either the Medicare or the Medicaid programs. So we have a situation in which 20 to 25 percent of our residents are, in effect, subsidizing the unwillingness of public funding sources to pay their fair share of the costs, a subsidy, Mr. Chairman, of approximately \$5 billion every year. That is an insidious form of taxation that I think we should put an end to.

That is troubling enough. Even more discouraging is the inherent contradictions within the President's proposal. On the one hand there is extensive discussion of the concept of subacute care. I

think the First Lady was eloquent in her discussion of her personal experience with her father following a stroke, who spent several days in a hospital when he really belonged in another setting. She talked about the need to remove the barriers to subacute care; yet we have in the President's proposal more barriers to the entry of nursing facilities into the arena of subacute care. If, in fact, under the President's proposal 60 percent of all facilities will not even have their current costs reimbursed, how are they to be induced to participate in the subacute program?

The involvement of nursing facilities in subacute care requires two essential components. One is capital and one is appropriate staffing. We have lost the opportunity to generate capital with the elimination of the return on equity payments to nursing facilities.

I must commend you. You recognized when we lost return on equity that that could only be a short-term program, that it had to be supplanted by development of a prospective reimbursement system.

I thank you for the dialog you conducted on that point with Mr. Vladeck this morning. We do have under the proposal for prospective reimbursement the potential to regenerate the capacity to develop capital so we can move into the subacute arena. But if, on the other hand, we see not only a continuation of the freeze on RCLs, but in fact a reduction in the RCL limit, that impacts on our ability to attract staff. That RCL reduction proposed by the President translates into an average \$15,000 per facility. That is the annual salary of a nurse's aide. We shouldn't be reducing the number of nurse's aids we employ. We should be increasing the number.

So I would suggest, one, that we are seeing in fact absolute cuts not simply reductions in the rate of growth; and, two, we are seeing an impact on patient care; and, number three, we cannot begin to move into this area of subacute care where there are untold billions of dollars to be saved if we are not allowed to generate the capital and attract the staff we need.

Thank you very much.

Chairman STARK. Thank you.

[The prepared statement follows:]

**TESTIMONY OF PAUL WILLGING
AMERICAN HEALTH CARE ASSOCIATION**

Mr. Chairman, members of the Subcommittee, I am Dr. Paul Willging, Executive Vice President of the American Health Care Association (AHCA). On behalf of our 11,000 nursing facilities that provide care for more than one million elderly and disabled people across America, thank you for the opportunity to address this panel. Mr. Chairman I commend you, for holding this hearing to address the provision of President Clinton's "Health Security Act" that will change the Medicare program. AHCA is particularly interested in the proposed reduction in skilled nursing facility routine cost limits.

I am pleased to be back in front of the Committee to expand on AHCA's views of the President's health care reform proposal. As I stated two weeks ago, AHCA supports the President's efforts to expand cost effective to all Americans. AHCA also believes that the cost of health care must be controlled. But, it must be controlled in a rational manner.

HCA adamantly opposes and is deeply disappointed in Section 4106 of the President's plan. Section 4106 dramatically reduces the ceiling on routine costs for services provided by skilled nursing facilities. This provision will devastate skilled nursing facilities' ability to provide quality care for current and future residents. Further, it is contrary to the Congressional intent to establish a prospective payment system for skilled nursing facilities.

AHCA strongly opposes the reduction in routine cost limits for skilled nursing facilities for three reasons:

- o This reduction will have a dramatically negative impact on the quality of resident care. Our initial data indicate it will reduce reimbursement to skilled nursing facilities by \$250 million in the first year alone.
- o This proposal is contrary to Congress' expressed intent to have a prospective payment system for skilled nursing facilities in place by October 1, 1995; and
- o This reduction will significantly reduce the effectiveness of Sec. 1119, the extended care or subacute benefit which facilitates the movement of patients in need of inpatient services into facilities that are an alternative to costly hospital care. Such a drastic reduction in routine cost limits will make it extremely difficult for skilled nursing facilities to provide care to subacute patients eligible for this benefit.

Additionally, Section 4106 is vaguely written, making it difficult to understand its exact meaning and determine its full impact on the industry. The title of the section labels it a "freeze extension." But contrary to the section title, its language does not describe a freeze, but a major reduction of routine cost limits from the current 112 percent of the mean calculation to 100 percent of the mean.

Skilled Nursing Facilities Routine Cost Limits

Payments for skilled nursing facility services are made on a reasonable cost basis. These payments are subject to per-diem cost limits based on 112 percent of the mean per diem routine service costs for freestanding facilities. Section 1888 of the Social Security Act authorizes the Secretary of Health and Human Services to limit per diem inpatient routine service costs for hospital-based and freestanding skilled nursing facilities by urban and rural locations. The Omnibus Budget Reconciliation Act of 1990 directed the Health Care Financing Administration (HCFA) to rebase the rates for cost reporting periods ending on or after October 1, 1992, and every two years thereafter.

Facilities with low volume Medicare patients (fewer than 1,500 Medicare patient days in the previous cost reporting period) are eligible for reimbursement on a prospective payment basis for all routine service costs and capital-related costs for extended care services. As with routine cost limits, there are separate rates for urban and rural facilities. The rate is equal to 105 percent of the mean of the per diem reasonable routine service and capital-related costs of extended care services for skilled nursing facilities within the same region. HCFA updates the prospective payment rate annually.

Prior to October 1, 1993, in addition to payments for the costs of providing services, proprietary skilled nursing facilities received a return on equity payment. This payment helped nursing facilities attract capital necessary to provide quality care by giving facility investors a return on their investment equivalent to what they would have earned for investing the same amount in specified government securities.

OBRA93 Cuts in Skilled Nursing Facilities Reimbursement

The Reconciliation Act recently passed by Congress imposed significant reimbursement cuts on the nursing facility industry. The impact of OBRA93 on quality of patient care is yet unknown.

Congress froze cost limits and prospective payment rates for skilled nursing facilities through fiscal year 1995. The Congressional Budget Office has estimated that this will reduce our reimbursement by \$511 million over the next five years.

Additionally, Congress eliminated return on equity payments to skilled nursing facilities effective October 1, 1993. This will reduce reimbursement by \$550 million over a five year period.

Return on equity payments provided skilled nursing facilities with equity capital to build new beds and to improve quality of care. Nursing facilities will now find it much tougher to keep pace with the growing demand for beds of an aging population and to acquire the necessary equipment to meet the increased demand from the extended care benefit in the President's health reform plan.

Nursing facilities still are reeling from these draconian cuts in reimbursement, and trying to assess the impact of these cuts on access and quality of care to our residents. We are especially concerned about the impact of these cuts at a time when the nation's aged population is growing and when reform will call on skilled nursing facilities to become a cost effective alternative for subacute patients.

Poorly Worded Section

AHCA is unable to establish the clear intent of Section 4106, nor determine its full impact on skilled nursing facilities. The contradiction between its title and its language make its intention difficult to understand. The section is entitled "Extension of Freeze on Updates to Routine Service Costs of Skilled Nursing Facilities." Yet the language does not contain an extension of the freeze. Rather, it reduces the routine cost limits from their current 112 percent to 100 percent of the mean effective October 1, 1995. The provision also would reduce payments determined on a prospective basis from 105 percent to 100 percent of the mean. The rates then are adjusted by the HHS Secretary to preserve savings from OBRA93.

Bruce Vladeck, in his testimony before the House Energy and Commerce Committee attempted to explain this provision. His written testimony states:

"OBRA93 established a two-year freeze on updates to the SNF limits. However, a "catch-up" would occur when the SNF freeze expires on October 1, 1995 -- limiting the savings to two years. This proposal will eliminate the inflation "catch-up", and

provide permanent savings by recalculating the percent of the mean that would produce the same amount of savings as if the freeze were continued."

It is unclear why the provision contains language to replace the 112 percent of the mean with 100 percent. Does HCFA anticipate having to reduce the mean to that level or will it go further? Let me be clear, such a reduction would be a devastating cut in reimbursement with grave effects on the industry.

Quality of Care At Risk

Skilled nursing facilities are currently not being fully reimbursed for care provided to beneficiaries. Nearly a quarter of free standing facilities have Medicare costs above the routine cost limits. There is little room to absorb significant and repeated reductions in reimbursement.

I have to assume from the bill language that we will see a reduction in routine cost limits from 112 percent to 100 percent of the mean. Based on this assumption, AHCA has conducted some initial estimates of the impact this provision will have on our industry. Mr. Vladek states this provision will reduce reimbursement to skilled nursing facilities by \$830 million over six years. We estimate that reimbursement to skilled nursing facilities will be cut by \$250 million in the first year alone impacting a full 59 percent of all skilled nursing facilities, who will experience a reduction.

Mr. Chairman, we have heard from the Administration that their plan will not cut reimbursement but will cut the growth in reimbursement. In addition, they label this provision a freeze extension. This is not a freeze but a real cut on per diem reimbursement. On a per diem basis, this amounts to a drop in routine reimbursement from the current \$92.13 per day to \$86.69 per day.

Let me translate this to its impact on quality of care. This cut will force the average nursing facility to lose about \$15,000 in revenue, or one nursing assistant salary. I think you will agree that we do not want to reduce the level of care we provide to elderly and disabled individuals in our facilities.

Weakens the Ability to Provide Subacute Care

Section 1119 of the President's health reform proposal adds an extended care or subacute benefit to the "guaranteed national benefits package" that all insurers would be required to provide. Individuals will be eligible for 100 days of care in a skilled nursing facility or a rehabilitation facility as an alternative to inpatient hospital treatment following illness or injury.

In testimony before the Senate Labor and Human Resources Committee, the First Lady offered the best rationale for this benefit stating "...under Medicare many older patients and disabled patients, patients who are under very severe medical conditions and often on life support are kept in hospitals because if they are moved out of the hospital government assistance for their care stops. I did not face that with my father, but I would have if he had not died...We want to provide reimbursement for subacute care at nursing homes rather than in the much more expensive hospital setting."

The cost effectiveness of subacute programs has been documented. For example, a 1991 study by Karl M. Kilgore found a 37 percent lower cost for individuals in subacute facilities than in inpatient facilities. It concludes that the subacute program was significantly more cost-effective in terms of functional gains made per dollar of expenditures. Other data demonstrates that upgraded skilled nursing facilities can provide care at an average two-thirds of the cost now charged by hospitals; a

savings of untold billions of dollars per year to the government and private sector.

This drastic cut in reimbursement, compounded with the 1993 cuts, will negate our ability to provide subacute services. Subacute residents require additional equipment and staff. Facilities can not provide these complex services when they are forced to cutback on staff and are unable to raise the capital to buy the necessary equipment.

Contrary to Prospective Payment System

I do not believe Congress intended to see the freeze on routine cost limits perpetuated indefinitely. While OBRA93 froze routine cost limits through fiscal year 1995, the conference report makes clear that this is an interim step until a prospective payment system can be enacted.

Congress has long advocated development of a prospective payment system for skilled nursing facilities. The Omnibus Budget Reconciliation Act of 1990 directed HCFA to develop and submit a proposal for such a system no later than September 1, 1991. HCFA is in the process of conducting a case-mix study that continues to collect data with no completion date in sight.

Frustrated with HCFA's pace, conference agreement on OBRA93 directed the Secretary to complete development of a prospective payment system and present recommendations to Congress in time for implementation no later than October 1, 1995.

The conference report further states that the "conferees believe that Medicare costs for skilled nursing facilities can best be controlled through a prospective payment system. Such a payment system will encourage provider efficiency and simplify administrative requirements." Mr. Chairman, we fully agree with the conferees. In a letter recently sent to this Subcommittee the HCFA Administrator, stated that he "shares your concerns about timely establishment of PPS for Medicare SNFs." Congress has called for this, HCFA recognizes the need for it and we want it. Let's make it happen.

A prospective payment system for all skilled nursing facilities will provide the Medicare program with savings by "leveling the playing field" between hospital-based and free-standing providers of skilled nursing care to like patients.

Currently, Congress sets the reimbursement limits for hospital-based skilled nursing facility at 50 percent of the difference between 112 percent of the hospital-based mean and 112 percent of the free standing facility mean. The national Medicare routine cost limit differential between these hospital "distinct parts" and free standing facilities, is an estimated \$45 per day.

AHCA believes that the recent Health Care Financing Administration study, done for the General Accounting Office on the relative acuity of Medicare patients in hospital-based and free-standing SNFs reinforces the fact that the current differential between the two is uncalled for and a waste of Medicare funds. Specifically, it provides evidence that the differential allows the hospital-based SNF to care for the same patients as the free-standing SNF at significantly higher rates and provides an opportunity for hospitals to cost-shift from the flat rate diagnostic related group to cost-reimbursed SNF care.

Thus, Medicare reimbursement differentials between hospital-based distinct part and free-standing SNFs encourages inefficient utilization of resources which is contrary to the President's effort to provide incentives for patients to be serviced in the most cost effective setting.

This provision maintains the current inefficient retrospective reimbursement system. Instead of exacerbating the problems of the current system with deep and arbitrary cuts, a new Section 4106 should be adopted that establishes a prospective payment system that reimburses facilities based on resident acuity,

efficiency incentives, and fair-value rental for property administrative costs. AHCA is happy to continue to work with the Committee on achieving this goal.

Conclusion

The reduction in routine cost limits embodied in Section 4106 of the President's health reform proposal is bad public policy. It will hurt resident care at a time when the industry Nursing Facility is still reeling from the impact of OBRA93 cuts. It is contrary to Congressional intent to establish a skilled nursing facility prospective payment system, and it will inhibit facilities from providing the subacute benefit in the President's comprehensive benefits package. We strongly recommend the section be substituted with language that establishes an equitable prospective payment system.

Chairman STARK. Mr. Tracey.

STATEMENT OF MICHAEL R. TRACEY, PRESIDENT, MINNESOTA ASSOCIATION OF HOME MEDICAL EQUIPMENT SUPPLIERS, PRESIDENT, HOM-OX-EQUIP, ON BEHALF OF THE NATIONAL ASSOCIATION FOR MEDICAL EQUIPMENT SERVICES

Mr. TRACEY. Thank you, Mr. Chairman. I am pleased to be here today on behalf of the National Association for Medical Equipment Services to discuss certain provisions contained in the Health Security Act of 1993.

NAMES represents over 2,000 suppliers nationwide that provide quality and cost-effective home medical equipment services. Specifically, the administration seeks to implement competitive bidding for oxygen equipment and other items and services as determined by the Secretary of the Department of Health and Human Services.

I was asked today to testify as the President of a home medical equipment company, and the President of the Minnesota Association of Home Medical Equipment Services, in a State where we have a lot of competitive bidding issues, and also as a respiratory care practitioner of 19 years. I certainly understand the needs of patients receiving care at home.

I have witnessed firsthand as a supplier and as a respiratory therapy director in a hospital that there is a negative, anticompetitive effect created from competitive bidding. Minnesota Medical Assistance, for example, mandates competitive bidding for wheelchairs and oxygen therapy. For that reason, I strongly oppose competitive bidding for medical equipment services, as does NAMES. Competitive bidding will not ensure quality home medical equipment services at reduced payment levels. It has been proven time and time again. Thus, overall, I believe that access to home medical equipment services to all Americans will certainly suffer. There have been a number of GAO and HCFA-initiated studies that support this claim.

Competitive bidding has been attempted and subsequently abandoned in many States due to implementation problems. Imagine the enormous complexities involved in creating multiple and reasonable service areas where only a few suppliers provide all of the necessary services. Consequently, rural American communities will suffer the most with competitive bidding because of the distances suppliers must travel from the metro areas.

Under the current Veterans Administration (VA) structure nationwide, we have competitive bidding in place for oxygen therapy. It has been documented that there are service delays ranging from 24 to 72 hours to set up and deliver an initial order for oxygen. That is inexcusable, and I believe that these service delays only cost the government more money in the long run due to extended hospitalizations. Delays of this type under the Medicare system will disrupt the current DRG system in place because people will be waiting for service.

To document the service component of the home medical equipment industry, studies have shown that 60 percent of our costs are related to wages and benefits, not the acquisition costs of equip-

ment as many believe—because our reimbursements are generally tied to that.

In my home State, there have been many service problems related to competitive bidding contracts such as with the MA contracts: Patient education and training is inadequate; followup and reeducation is somewhat nonexistent; equipment checks to make sure the equipment is working properly are not routinely performed; 24-hour service lags for delivery from when the initial order is received; and some companies have no professional staff to support these patients' needs in the home.

In addition, maintenance checks on the equipment run intervals of 6 to 9 months, whereas typically we like to see our patients on a monthly basis. The importance of that is to create a good base of patient, physician and supplier interaction that will allow good management of the overall case of the patient in the home. In fact, the supplier I believe in many cases is the physician's eyes and ears in the home.

To demonstrate further, I would like to talk about my company for a minute. We have experienced recently a series of Medicare claims denials for some of our Medicare patients receiving oxygen, not because we didn't provide the care, but because we did it too well. The bottom line is that patients had not seen a physician or had been hospitalized in over a year, therefore, not allowing their certificate of medical necessity to be renewed and thus resulting in payment denials. Conversely, we have documented many cases in hospitals where unnecessary readmissions of Medicaid patients under the contracted oxygen bid have occurred.

Single provider systems such as in the administration's proposal in any given particular area will not work. Many small home medical equipment suppliers will go out of business. As that happens, decreased competition will occur and decreased choice for quality providers. I believe that beneficiaries and their physicians and referrals deserve the freedom to choose quality providers for their patients and for the patients themselves.

Competitive bidding does not give them that option. Home care, specifically home medical equipment services, represents only 2 percent of the total Medicare budget, and home medical equipment services also is cost effective and an integral part of the overall health care delivery system.

The Federal Government, I believe, should not consider jeopardizing the access to home medical equipment services by instituting competitive bidding or a further reduction in fees because potentially costs could increase the overall costs of health care. I do believe that currently the Federal Government is paying the fair market price for these services.

In summary, based on the accumulated evidence that demonstrates inadequacies of competitive bidding and because of the adverse impact that such a system will have on patients, home medical equipment providers and the entire health care system, NAMES strongly opposes competitive bidding for home medical equipment services.

Thank you, Mr. Chairman.

Chairman STARK. Thank you.

[The prepared statement follows:]



Testimony
 of
Michael R. Tracey, President
Hom-Ox-Equip Company
 and
Representing the
National Association for Medical Equipment Services
 on
Competitive Bidding
 before the
Subcommittee on Health
House Ways and Means Committee
Hearing
of
Tuesday, November 23, 1993

Mr. Chairman and Members of the Subcommittee: I am pleased to be here today on behalf of the National Association for Medical Equipment Services (NAMES) to talk about the competitive bidding provisions contained in the "Health Security Act of 1993." NAMES represents over 2,000 home medical equipment (HME) suppliers, who provide quality, cost-effective HME and rehabilitation/assistive technology equipment and services to consumers in the home.

NAMES and the HME services industry applaud the Administration for including HME services and custom devices as part of its "standard benefits package" because HME is demonstrably cost-effective and consumers far prefer to recuperate from an illness or injury at home. But, as the health care reform debate advances, with the goal of maintaining and improving quality health care for millions of Americans, NAMES believes Congress should not consider implementing competitive bidding for the HME services industry as proposed in the Administration's plan.

Specifically, the Administration's plan seeks to implement competitive bidding for oxygen and oxygen equipment, parenteral and enteral nutrition (PEN) and other "such other items and services" as determined by the Secretary of the Department of Health and Human Services. This provision is part of the \$238 billion in Medicare and Medicaid cuts over five years that will help pay for the Administration's proposal.

As the President of both an HME services company and the Minnesota Association of Home Medical Equipment Suppliers, I have witnessed first hand the negative effects of competitive bidding, as Minnesota's Medicaid Program currently allows for competitive bidding on wheelchairs and oxygen equipment. For that reason, I oppose competitive bidding for the HME services industry, as does NAMES. Competitive bidding will not ensure quality HME services at reduced payment levels and could curtail access of home medical equipment to all Americans. All available evidence supports this assertion.

COMPETITIVE BIDDING STUDIES

In 1986, the General Accounting Office (GAO) studied eight Health Care Financing Administration (HCFA)-initiated competitive fixed-price contracts, conducted on an experimental basis for Medicare carriers and intermediaries. After examining seven of the contracts, GAO concluded that HCFA lost money on four of them (Medicare - Existing Contract Authority Can Provide for Effective Program Administration, GAO/HRD-86-48, April 1986). In that same report, GAO made the following observations:

- A major change in the method of contracting used in the Medicare Program is not justified because the competitive fixed-price experiments have not demonstrated any clear advantage over cost contracts presently used to administer the program;
- The frequent use of this method of contracting could increase Medicare administrative problems, including the risk of poor contractor performance; and
- There is potential for disrupted service.

HCFA also has studied and recommended the implementation of competitive bidding for many years — without success. Between 1985 and 1990, Abt Associates of Cambridge, Massachusetts, was under contract with HCFA to evaluate competitive bidding as a method of purchasing home medical equipment. One Abt Report Summary stated that:

“Competitive bidding processes per se will not necessarily result in lower Medicare costs (service and administration) for DME or clinical laboratory services in comparison to other available reimbursement methods. The ability of competitive bidding to realize savings for Medicare, while safeguarding quality, depends critically on the design, implementation and subsequent administration of the bidding system adopted. This review of the empirical literature has raised a host of issues for DME and clinical laboratory competitive bidding demonstrations, while providing considerably fewer findings that can be put forward with confidence.”

From these studies alone it is clear that competitive bidding on HME should not be an option for the Medicare program. NAMES does not oppose competition in the health care marketplace, provided that the quality of patient care and services are maintained. However, no data have been presented to indicate that inadequate competition exists today in the HME services marketplace. Indeed, the increasing number of new entrants indicates that competition is flourishing.

COMPLEXITY OF IMPLEMENTING COMPETITIVE BIDDING

Competitive bidding for certain HME items has been tried and subsequently abandoned in a number of states, no doubt due to implementation problems. Imagine the enormous complexities involved in dividing the entire nation into multiple and reasonable service areas, since few HME suppliers provide all possible HME services. Let me highlight a few examples:

- Rural communities across America will be most affected as they will not have access to hundreds of medical equipment supply items;
- Successful bidders for oxygen and other major products will not be able to provide reasonable coverage for the delivery of the full spectrum of HME items and services to all of the areas and regions throughout America; and
- Successful bidders will be delivering a significant portion of HME services. Therefore, the smaller companies that provide and service less costly and lower volume items simply will not be able to continue to provide delivery of these items, subsequently forcing them out of business. Severe delivery delays for equipment and services by large companies that may maintain their presence through the bid will occur because of the high cost of delivering HME beyond any reasonable distance, across urban areas and throughout rural areas. Thus, hospital discharges to the home will be delayed and hospital admissions will increase, while patients are waiting for the required equipment to be cared for at home.

COST OF COMPETITIVE BIDDING

Under competitive bidding structures that currently exist for oxygen in the Veterans Administration (VA), there are expectations of equipment delivery time that range from 24 hours to 72 hours from the time the order is initiated. This is necessary to allow the bidder, who now has the contract, time to service the large geographic area as well as allow them to be as efficient as possible so they can stay in business under the lower competitive bidding rates.

- With delivery delays, there will be an increase of overall health care delivery costs. Patients will experience delays in discharge (which will severely disrupt the current DRG structure under Medicare Part A), while waiting for service.

- Under a competitive bid structure, the service levels will deteriorate significantly. Follow-up visits by health professionals that facilitate ongoing and thorough patient/physician/provider interaction, patient/caregiver education and monitoring of adherence to physician orders will be eliminated or considerably reduced.
- Emergency service (24 hours per day) will be compromised because of the distance that companies typically travel to care for patients under a competitive bidding structure. Routine maintenance checks of equipment servicing will be cut back due to cost constraints, causing concern for patient safety. All these things contribute to increased costs of providing health care.
- If only one re-admission for acute exacerbation of COPD occurs, which otherwise could have been avoided by providing the high level of in-home service that exists today, the cost of that admission for the federal government will exceed the savings achieved under competitive bidding for that individual patient for several years.

THE SERVICE COMPONENT

With any competitive bidding system, the first issue to consider must be a determination of what level of service provided by HME suppliers the government is willing to pay. Otherwise, the government should be concerned that the service component — so integral to assuring patient health and safety — may diminish or disappear. In my home state, I have heard of a number of service-related problems associated with Minnesota Medical Assistance Contracted Providers, those companies that have been awarded Medicaid contracts with the state. Some problems include:

- Inadequate patient education and training on equipment;
- Poor professional follow-up services to determine if the patient is properly using the equipment;
- Irregular equipment checks to determine if the equipment is properly working; and finally,
- Contracts allow a wait of as long as 24 hours from the time the initial physician's order is received by the supplier until the equipment is delivered and set-up.

Americans with disabilities will suffer significantly under competitive bidding because access to the custom, highly specialized equipment that they require will diminish. We estimate that the small percentage of HME suppliers who could remain in business under this type of structure would not be able to provide this type of high cost, low margin and highly serviced equipment to all corners of the country.

My company services approximately 100 oxygen patients with 90 of them being Medicare beneficiaries. Typically, we provide an average of three after hours (evenings and weekends) calls per week to provide emergency service to patients or new set-ups. If these patients were not adequately serviced on a timely basis, then costly hospitalization would result. Often, new orders for oxygen in the home are initiated from an urgent care clinic or hospital emergency room, thereby avoiding hospital admission.

Under competitive bidding, a rapid response time by a limited pool of providers will not be possible; this could result in an additional hospital admission, which will be extremely costly. Imagine extending the above numbers across the country under the Medicare program.

IMPACT ON SMALL HME SUPPLIERS

Implementing competitive bidding would radically restructure the way HME services are provided. Further, it will be very hard to design and administer any competitive bidding process without damaging the market. If a winning bid is awarded solely to one provider within a given "service area," as currently proposed by the Administration, this certainly will drive many small companies out of business. The sole winner in future years thus would have a considerably reduced level of competition — and considerably reduced choices for consumers in choosing an HME provider.

Under competitive bidding, winning companies could resort to using "predatory pricing" techniques, knowing they will have a monopoly on the market and eventually will be able to drive costs back up as competition will no longer exist. The outcome again is poor service and quality, limited access and short- and long-term increased costs of health care.

Another HCFA-initiated Abt report substantiated the claim that competitive bidding might force some suppliers who participate in the Medicare system out of business:

"...complete loss of that business would place most suppliers in an extremely tenuous financial situation. For this reason, a bidding system that totally disallowed Medicare reimbursement for customers who choose to use losing suppliers would definitely reduce some suppliers' business and eventually force them out of the market."

OTHER COMPETITIVE BIDDING MODELS

Competitive bidding is known to work poorly both for the Defense Department and the VA, where this technique already is used on a large scale, similar to what Medicare would require. VA hospitals have experienced deficiencies documented by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) due to the poor quality of home care provided by VA competitive bidding contract winners.

Under the Administration's plan, we would have to expect similar, if not greater, problems in access and quality. The VA, once acquiring a signed contract in certain states, has monitored the provider for provisions of services only to find they have no awareness of home oxygen and HME items in the areas of: quality; appropriateness of equipment; various types of equipment; safety features of equipment; and current pricing of equipment.

British Columbia, Canada, has had a competitive bid process for HME services in place since November 1991. There, the government uses a scheme of establishing a "preferred" provider based on lowest bid and up to 2 "approved" providers based on next lowest bid in each health unit (7 units in British Columbia). Typically, this system allows for:

- 48 hours to set up new patients, from time of initial order;
- A three year bid period with the government option to renew every year if the provider is not performing based on confirmed complaints;
- Concentrators, liquid oxygen systems, portable systems and contents to be bid and paid for separately. Contents are based on actual usage;
- Government mandates on patient follow-ups/assessments done every 6 months as a minimum, but can be done more often if so desired;
- Government mandates that require concentrators to be maintained at a minimum of every three months and more often if desired;
- The preferred and approved vendors compete on service and are permitted to obtain clients based on referral, physician or patient preference, even though providers will be paid at different rates based on their bid; and
- An overall decline in service levels because patients have remained in hospitals longer. Service delays and hospital admissions have more than likely increased because of minimal patient/provider/physician interaction.

Based on the accumulated evidence that demonstrates the inadequacies of competitive bidding and because of the adverse impact we predict that such a system would have on patients, HME providers and the entire health care system, NAMES strongly opposes competitive bidding for home medical equipment services.

Chairman STARK. Mr. Tracey, what city is your your oxygen respiratory and supply, Hom-Ox Equipment Company located?

Mr. TRACEY. The city? Red Wing, Minnesota. We are in a rural community about 60 miles from the Twin Cities.

Chairman STARK. Make boots?

Mr. TRACEY. Yes, and shoes.

Chairman STARK. And shoes. OK. Are you effectively the only supplier in that town?

Mr. TRACEY. We are the only supplier in the community. We do have a local pharmacy that does supply some minor items, but essentially we are the only supplier.

Chairman STARK. So basically if I get emphysema I do business with you eventually?

Mr. TRACEY. Yes.

Chairman STARK. So I pay what you charge unless it is a reimbursement under Medicare or something else or whatever Blue Cross will pay, but I negotiate with you or I don't get the oxygen pretty much, so you are not really a good example of what happens, say, in Oakland or in Chicago where there are probably a lot of suppliers, right?

Mr. TRACEY. Well, typically in the metro areas there are a lot more suppliers, but in our industry—it is kind of interesting that you ask that because I am about 45 minutes from Rochester, Minnesota, which is of course where the Mayo Clinic is and there are a number of suppliers there and they would be more than willing to come to Red Wing to take care of patients 45 minutes away, and if we weren't competitive in both our quality of service and our price I think that would happen.

Chairman STARK. OK. Now what would you think of this kind of a system, we just had a court case in San Francisco, Alta Bates Hospital had a deal with the docs, and for years if you were discharged from Alta Bates and you would pay your bill, then the hospital would give you a list, they would say, here, you need oxygen at home, here is a list of five or six people in the East Bay, or wherever you live, and they are all good folk, call them up and get the service. Do you think that is a fair way? Does that sound fair to you?

Mr. TRACEY. Most definitely. I believe that that is the way it should be.

Chairman STARK. OK. Now what happened, though, is that Alta Bates had the good idea that this was silly, so they bought one of them, and then that was the only name you received. As a matter of fact you were signed up before you left the hospital, you had to buy from the company that the hospital and these docs owned, and several people, one being my constituent, went out of business, arguably because a couple of other hospitals did the same deal, and they didn't get any referrals. I mean, the yellow pages didn't help them much. Do you think that is fair?

Mr. TRACEY. No, I don't.

Chairman STARK. OK.

Mr. TRACEY. We have several companies.

Chairman STARK. I don't either. But then, on the one hand, you are in an area where there is less competition for one reason, just

because you are in a remote area, and then we had the folks in my area who just eliminated competition.

Now, they got put out of business and that by the court who decided that was really unfair competition, and I think we both agree that it is, but is there some middle ground particularly with reference to Medicare, what if we just said that we would get some kind of an average price in an area, then anybody who cares to meet the price could serve, that is about what we do now, isn't it?

Mr. TRACEY. That is basically how the fee schedules are set up now, yes.

Chairman STARK. You could live with that?

Mr. TRACEY. Live with the current fee schedule structure?

Chairman STARK. The system, not necessarily the fees themselves. None of you like the fees we pay now, but I am just saying that the structure is OK?

Mr. TRACEY. I have to believe that the current structure in place is working real well.

Chairman STARK. OK. Now, I got a little problem here as between Mr. Halamandaris and Mr. Willging, and some other guys who chose not to testify. Mr. Halamandaris, I am puzzled, so I will let you unpuzzle me. How come the for-profit guys in your business are salivating at the idea of having prospective DRG payments and you don't think they are so good? Tell me what you are suspicious about, what are these profit guys trying to pull over my eyes?

Mr. HALAMANDARIS. Well, I don't think that is it, Mr. Chairman. By definition it is a cost-based system, and Mr. Willging pointed out that means there isn't any profit in it. There used to be a factor that you know very well called return on equity.

Chairman STARK. All these nonprofit friendly guys around here, all right.

Mr. HALAMANDARIS. There used to be a factor for return on equity, and we deleted that years ago, so there used to be some opportunity for people to reclaim capital, so I am sympathetic, and I would like to divorce the home care part of it and the nursing home part of it because I think we have a better understanding of how to do prospective payment in the area of the nursing home.

With respect to home care, there really is a lot we do not know. We don't know how to design a system that is not going to hurt patients at the present time. We don't really know how to create a system that is not going to cast a shadow over our whole industry. We don't know how to design a system that will give the government the accountability that it needs. We have been working very hard to do that, but there are some inherent difficulties right now. All we can come up with—

Chairman STARK. Magaziner has got one, he is going to have the alliances take care of that. It is in that bill.

Mr. HALAMANDARIS. Well, there are inherent inequities that are still there to be defined within the bill. It costs a lot more to deliver services in urban areas of high risk than it does out in the suburbs. The geography is not taken into consideration, neither is the acuity of patients. Those are two very, very important factors.

The heavy care patients in home care would be snubbed or wouldn't be taken care of or would only be taken care of by those

nonprofit agencies that have other resources to supplement their care.

It would also create a windfall profit for the unscrupulous. Human nature being what it is, Mr. Chairman, if you give me a flat fee and I can decide for myself how much to allocate to patient care and for profit, there are going to be some people that are going to keep an unfair and an untoward amount for profit.

I also believe that it is important that those studies that the Congress mandated many times HCFA undertake be completed as rapidly as possible to give Congress and the rest of us the information that we need. We have been supporting that and pushing that, and I think it is so important that we get to the point where we can do something responsible. At the present time, I don't believe we can.

Chairman STARK. OK. Mr. Zawiski, the way I read it, the President's plan is trying to—some people have said, I haven't characterized it quite this way, trying to herd people into managed care programs. You have heard that statement made. There is a lot of incentive.

What is going to happen to your members when these large plans figure out that they might as well provide dialysis within the plan? Does that concern you?

Mr. ZAWISKI. It is a concern, Mr. Chairman. In fact, in the Miami area where my clinics are located, we have quite an aggressive managed care marketplace.

Chairman STARK. So you do. You have more marketing than you do service.

Mr. ZAWISKI. There is a concern what the impact of managed care in general will have on our industry. A lot of our members from all over the country have not had much exposure to managed care concepts and negotiating agreements with managed care programs. We are attempting—

Chairman STARK. Do you have any contracts with managed care?

Mr. ZAWISKI. Yes, sir, I do.

Chairman STARK. Do they get a lower price out of you than Medicare pays you?

Mr. ZAWISKI. We are basically contracting at Medicare rate these days, at Medicare rate.

Chairman STARK. Come on. They are getting something. What are they getting on top of that? I mean, do they like you to play golf with them? Why do they come to you rather than your competitor?

Mr. ZAWISKI. Well, there is a combination of the referral patterns with the nephrologists. Our nephrologists that are associated with my group have historically been very active with the managed care programs in our community before they really started becoming in vogue. It has been a particular marketing thrust of our organization, so we have had some agreements in place perhaps out of foresight, perhaps out of just good luck that have enabled us to do fairly well.

We have found that the managed care programs are communicating regularly with Medicare in terms of Medicare allowable rates. There is no cost shifting opportunity there whatsoever. They know exactly what Medicare allows, they know exactly what Medicare

pays, they get the information from Medicare on computer tapes, and they do attempt to negotiate very hard.

There is a point where what we are finding in the dialysis industry, as I have mentioned in my testimony, costs are rapidly and relentlessly approaching the cost of the Medicare composite rate, Mr. Chairman, and certainly I could not be in business to negotiate a deal to provide a service for a managed care program or anyone else below my cost, so we just don't do that.

Chairman STARK. OK. Mr. Tracey, I forgot to ask you about the Abt Associates of Cambridge who did a HCFA study on competitive bidding. Do you know whether any competitive bidding demonstration projects have been started as a result of that?

Mr. TRACEY. No, there haven't been any at this point. The only competitive bidding projects we know about are the ones that I mentioned.

Chairman STARK. Hope, you testified that competitive bidding hasn't been successful, and you referred to the Air Force experience. What are you going to do? Is that going to carry over if you have got to compete? Let's say there are going to be three or four plans in a major alliance area, aren't you going to have—where they have to bid, in effect, aren't you in turn going to have to bid to these large plans?

Ms. FOSTER. I think we are going to have to wait and see whether that occurs. Some of this may occur through negotiation rather than a formalized competitive bidding process. The problem—

Chairman STARK. But if it did, that wouldn't necessarily—that would be a government edict, that would just be the plan saying—

Ms. FOSTER. Sure.

Chairman STARK. How many large nationwide labs are there? Two? Three? Four?

Ms. FOSTER. Oh, there are probably about five right now.

Chairman STARK. That are big and nationwide?

Ms. FOSTER. That are nationwide.

Chairman STARK. If I were a plan starting someplace or bidding in, in a community where at least two or three of those laboratory plans were working and we were somehow putting this together, why wouldn't I get a bid, particularly on most of the routine high volume tests?

Ms. FOSTER. Well, you might. I don't know, but I think—

Chairman STARK. Would you have an objection to that if that were—

Ms. FOSTER. I am not here to talk about how the plan itself should conduct itself.

Chairman STARK. No, I am just saying with that kind of bidding if that were something that an independent private group decided to do with one of your clients or members independently—

Ms. FOSTER. Well, I think that is between them.

Chairman STARK. That doesn't trouble you? If that is what they want to do—

Ms. FOSTER. I would hope that they would consider the possible consequences downstream of what might happen in that situation, and I hope that they would engage in a negotiation process as opposed to a competitive bidding, winner-take-all exclusive arrange-

ment, which is what I understand the President has proposed for Medicare.

If I were a plan, I would never rely on a single supplier. I think it is dangerous, and so I think a prudent plan would certainly enter into a contract with suppliers, but I would imagine it would be more than one supplier, and I imagine it would be through a negotiation, and I imagine it would be through some give and take on price and how the service would be supplied. I think the notion of winner-take-all leaves you terribly exposed if you are responsible for making sure these services are available to those you are protecting, be they Medicare beneficiaries or enrollees of a health care plan.

Chairman STARK. Mr. Willging, you think the administration's plan gives you sufficient flexibility to provide your services, your subacute services?

Mr. WILLGING. Well, it depends on which part of the plan you look at. If you look at some of the verbiage that surrounded it, it is wonderful. It talks about subacute. It talks about how important appropriate placement is. It talks about moving people, in fact, from hospitals into nursing facilities, into home care and hospice care. It talks about moving people out of nursing facilities into assisted living. It sounds wonderful, but the devil is sometimes in the details, Mr. Chairman.

When I look, then, at a reduction in the RCLs from 112 percent of the mean to 100 percent of the mean, I realize that what is being touted in the verbiage is not in fact what is being implemented in the legislative details. There is no way nursing facilities can be induced into subacute care if in fact that reimbursement isn't going to even consider the costs of the normal typical patient today, much less the subacute patient of tomorrow.

Chairman STARK. Well, we have our work cut out for us. I appreciate your willingness to help us as we wind through this, and I appreciate your patience for today's long wait, but your testimony is helpful. We look forward to continuing.

Mr. WILLGING. You were up until 2, Mr. Chairman. I admire your patience.

Chairman STARK. Thank you. The committee is adjourned.

[Whereupon, at 4:15 p.m., the subcommittee was adjourned.]

[Submissions for the record follows.]



ABC Home Health Services, Inc.

"Keeping Families Together"

February 28, 1994

Janice Mays
Chief Counsel and Staff Director
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, DC 20515

Dear Ms. Mays,

Please accept the following for the subcommittee on Health, Committee on Ways and Means. Pursuant to your formatting requirements, we submit this documentation on behalf of ABC Home Health Services, Inc. and The American Federation of Home Health Agencies (AFHHA).

If ABC or AFHHA can assist you in any way, please contact myself at 1-800-777-6876, ext. 4107, or Ms. Ann Howard, Executive Director, AFHHA at 301-588-1454.

Sincerely,

A handwritten signature in dark ink, appearing to read 'Joel V. Mills', with a long horizontal flourish extending to the right.

Joel V. Mills
Administrative Assistant to C.E.O.

JVM:sew



ABC Home Health Services, Inc.

"Keeping Families Together"

Home Health Reimbursement Under Medicare – It's Time for a Change

Under current law, Medicare reimburses Home Health Agencies (HHAs) for the actual reasonable costs, up to the level of annually published "cost limits," incurred for services related to the care of beneficiaries. This Medicare payment method is called a cost-based or cost reimbursement system.

It can be argued that the cost reimbursement system -- in addition to being extremely burdensome for HHAs with its paperwork and regulatory requirements -- has contributed to rising costs within the Medicare program by failing to provide any incentives for providers to operate in a cost-efficient and effective manner. To the contrary, there is every incentive not to do so, as Medicare reimburses for costs up to the cost limits currently set as 112 percent of the mean.

Other Medicare providers, such as hospitals furnishing inpatient services, are not paid for services under a cost-reimbursement system. Since 1983, hospitals have been reimbursed prospectively. That is fixed payment amounts are established in advance of the provision of services and providers are paid based upon this predetermined amount. This payment system has resulted in reducing costs to the Medicare program. For example, it is estimated that the growth in total inpatient spending between 1985 and 1991 would of been 12 percent per year under the former cost reimbursement system. Under the present system, annual growth has been 5.1 percent.

The replacement of the current cost reimbursement system for HHAs with a system that would establish fixed, **standard payment rates** in advance of services would also yield savings to Medicare. It is time for Congress to consider and enact such a change. The standard payment system, by establishing a single or standard payment rate for each type of home health visit within each geographic area, gives incentives to providers of care to maximize efficiency. The federal government and the American taxpayer would benefit from such a system. First, savings would accrue to the Medicare program because a standard payment rate could be set below the level of the current cost limits. A second benefit would be the promotion of cost-consciousness among providers, a factor that would ultimately contribute to the slowing of the growth of overall health care costs. Home health providers themselves would benefit by knowing in advance the rate of payment they will receive for services rendered to eligible Medicare patients and by being relieved of the onerous regulatory burden of the current cost report, which would be replaced with a simplified reporting system. Patients would benefit because instead of spending hours focusing on regulatory requirements that have no relation to the furnishing of quality patient care, under the standard payment system providers could turn more attention to the real issue, caring for patients.

ABC Home Health Services, Inc., 1994

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ABC Home Health Services, Inc.

"Keeping Families Together"

1993 TOTAL VISITS BY STATE

<u>STATE OFFICE</u>	<u>TOTAL VISITS</u>
ALABAMA	159,753
ARKANSAS	159,753
CALIFORNIA	272,743
COLORADO	29,419
FLORIDA	914,623
GEORGIA	1,111,437
ILLINOIS	182,965
INDIANA	11,631
LOUISIANA	10,762
MICHIGAN	219,832
MISSOURI	11,852
NEW MEXICO	54,156
OHIO	35,435
OKLAHOMA	13,318
PENNSYLVANIA	465,713
TENNESSEE	634,610
TEXAS	159,833
VIRGINIA	73,051
WEST VIRGINIA	19,052
<u>GRAND TOTAL FOR ALL STATES</u>	<u>5,034,626</u>

Health Care Reform

1994 WINTER EDITION

The Medicare Home Health Perspective

Prepared by the



American Federation of
Home Health Agencies, Inc.

1320 Fenwick Lane, Suite 100
Silver Spring, MD 20910
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Table of Contents

Principles for a Reformed Health Care System	1
Home Health Care As a Standard Benefit	1
Home Health Care As Long Term Care	2
Medicare Reductions	3
Preservation of Market Access and Consumer Choice	4
Medicare-Certified Home Health Agencies Licensed and Regulated	5
Glossary of Terms	6

National Home Health Services Alliance

c/o 1320 Fenwick Lane, Suite 100
Silver Spring, MD 20910

"Any health care reform must include home care as a core benefit -- because home health is part of the solution."

Phone: 301/588-1454 or 703/836-9863
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PRINCIPLES FOR A REFORMED HEALTH CARE SYSTEM

A reformed health care delivery system must provide for consumer access to a broad range of home health care, including acute, primary, preventive, rehabilitative, and long term care services.

In addition to home health care services and items currently covered under Medicare (skilled nursing, physical therapy, speech therapy, occupational therapy, medical social worker, home health aide, supplies, and durable medical equipment), all health plans should include coverage of home infusion therapy, respiratory therapy, and long term care for those with chronic disabilities and illnesses.

Americans prefer home health services to institutionalization because home health care is a more humane modality of care, one which maximizes independence and dignity. Home health care enables those in need of health care services to remain at home and in the community, while encouraging a quicker recovery and return to productivity.

In the great majority of cases home health care is much more cost effective than hospitalization or other institutional services. A reformed health care system should build on the lessons learned by private employers and insurers who have saved millions of dollars by expanding the role of home health care from strictly post-hospital acute care to include primary, preventive, rehabilitative, and long term care services.

Home Health Care As a Standard Benefit

- I Home health services are and should continue to be a standard acute care service for American consumers. Covered services should include skilled nursing, physical, occupational, and speech therapy, medical social services, home health aide services, medical supplies, durable medical equipment, and home infusion drug therapy services.
- II Home care is a key component of health care services in employer-sponsored and private insurance. Consumers should suffer no loss of current benefits.
- III Primary, preventive, and rehabilitative services should be provided in the most cost-effective and efficacious setting, whether in the consumer's home or elsewhere.
- IV A reformed health care system should take advantage of expandable and contractible home health care services to increase access to health care in rural and inner city areas without incurring the capital expense of facility construction

-
- V Home health care is a cost-effective service, and therefore should not be limited by arbitrary or artificial requirements.
 - VI There should be no limits placed on home health care services which do not exist for other settings such as hospitals, nursing homes, or community and ambulatory care settings.
 - VII Home health care services should be provided in accordance with a plan of treatment developed cooperatively by the physician, the patient and his or her family, and the home health care agency. Home health care should not be subject to cost sharing since like preventive services, prenatal care, and case management services, because home health care serves to help patients avoid more costly institutional care.

Home Health Care As Long Term Care

- I Home health care should be a core benefit of any long term care plan. Home care includes not only personal assistance but also nursing and home health aide services, rehabilitation services, and social services.
- II Consumers of long term care services should have access to a coordinated continuum of services, depending on their conditions and personal preferences. The range of services should include nursing home care, home health care, case management, homemaker and chore assistance, home modifications, respite services, assistive technology, adult day services, and rehabilitation.
- III Home health agency providers should be eligible to serve as case managers and care coordinators for patients receiving a continuum of long term care services, as home health agencies have for decades under both private and government-sponsored programs.
- IV States should be given flexibility to craft their own benefit packages and service models, subject to minimum federal standards. The long term care benefit should include coverage for a minimum set of services which would apply uniformly across the country.
- V The long term care benefit should cover all disabled persons regardless of age if they meet eligibility criteria.
- VI Quality outcome standards should be comprised of practice guidelines and patient/consumer satisfaction criteria. The same quality assessment criteria should be used to evaluate both agency-provided and consumer-directed services.
- VII Funding for the long term care benefit should not be based on savings resulting from reductions to the Medicare and Medicaid programs.
- VIII The long term care benefit should include incentives to provide services efficiently and cost effectively, such as provider payment methodologies which contain incentives to hold down costs.

Medicare Reductions

- I Expanded Medicare home health services, including coverage of infusion therapy, should be utilized as a cost control mechanism in a reformed health care system in order to reduce utilization of higher cost institutional care.
- II The integrity of the Medicare home health benefit should be preserved. The Administration and Congress should not revert to the restrictive home health model of the mid 1980s, i.e., home health care as a short term acute-care post-hospital benefit.
- III The home health benefit should not be asked to sustain disproportionate savings through actual reimbursement reductions while other types of providers are subject only to reduced inflation adjustments.
- IV Medicare home health agencies should not be expected to operate at a financial loss. The Administration and Congress should reject proposals to reduce home health cost limits to 100 percent of the mean on July 1, 1996, and to 100 percent of the median on July 1, 1997, especially in light of the reduced limits of July 8, 1993, and the two year reimbursement freeze imposed on OBRA 1993.
- V The quality of home health care and beneficiary access should not be compromised by cost limits set artificially low. Home health cost limits should be adjusted annually to reflect the cost of mandates such as home health aide training and competency evaluation, new electronic billing requirements, higher gasoline taxes, and new employer mandates in a reformed health care system.
- VI There should be no imposition of cost sharing on home health beneficiaries. Copayments would create barriers to access and to appropriate utilization of home health care services. Home health providers should not be saddled with costly and counter-productive administrative burdens such as the collection of copayments.
- VII Institutions, agencies, or persons who have provided services and determine that Medicare home health services are medically indicated must advise beneficiaries of their right to obtain home health services from the home health provider of their choice. The referring institution, agency, or person must furnish beneficiaries with a list of qualified providers and must honor their choice.
- VIII Any legislation calling for capping of entitlements and/or sequestration of Medicare payments as a budget enforcement mechanism must provide cost reimbursed home health agencies as alternate method of applying across-the-board cuts, e.g., establishment of standard payment rates or reduction of the home health cost limits rather than a reduction of payments for costs already incurred.

Preservation of Market Access and Consumer Choice

- I There should be a clear statement that no provision in a health reform plan is to be construed as permitting monopolization, attempted monopolization, conspiracy to monopolize, or other restraint of trade which is prohibited under the Sherman Act, the Clayton Act, or the Federal Trade Commission Act.
- II Health reform proposals which call for the establishment of "health plans" or "AHPs" should provide for competition at the provider level as well as at the plan level. Accordingly, providers in health plans must be selected by a competitive process which utilizes objective criteria including quality, price, services, and patient satisfaction.
- III A description of any competitive selection process and the criteria to be used must be published and made available to interested providers upon request sufficiently prior to the selection determination to permit all interested providers a fair opportunity to participate.
- IV There should be a periodic evaluations of participating providers and an "open season" at least every two years in which new providers have an opportunity to demonstrate that they can fulfill the search criteria better than participating providers.
- V Consumers should be given a choice of providers, and providers should honor that choice.
- VI A state should not limit or prohibit competition among providers to participate in a health plan by any antitrust exemption or otherwise.
- VII No provider or integrated health system will be provided "safe zone" protection under guidelines published by the Department of Justice and the Federal Trade Commission where the provider or system has market power (more than 20 percent) in a particular health care product or geographic market.
- VIII Providers and other health care organizations seeking the protection of "safe zones" under Department of Justice or Federal Trade Commission guidelines must contemporaneously publish notice in a local newspaper of general circulation generally describing the nature of the project. The rationale for the foregoing principle is two-fold:
 - (a) those seeking an exemption from the public policy expressed in the antitrust laws should be required to provide at least some notice to the public, and
 - (b) interested parties should have some minimal opportunity to alert the Department of Justice and the Federal Trade Commission to local market conditions which may be material to their determination.

For more information contact Ann Howard at the American Federation of Home Health Agencies (301/588-1454) or Mark Ranslem at the Home Health Services and Staffing Association (703/836-9863).

Medicare-Certified Home Health Care Agencies Licensed and Regulated

There is some confusion in the minds of public officials and the general population about the terms **home care** and **home health care and services**, since several different types of businesses provide some form of health-related services in an individual's home. Not all of these services, however, require the same level of skill on the part of the provider. While all services provided in an individual's home can rightly be referred to as **home care**, not all should be termed **home health care**. A brief description of the services offered by **Medicare-certified** home health agencies, as contrasted to services furnished by other providers, helps distinguish between the terms.

Home health care providers offer **skilled nursing care**, delivered by RNs and LPNs, as well as a broad array of other services such as occupational, speech and physical therapy, medical social services, and home health aide services. In addition, some agencies provide infusion therapy services. These home health agencies typically provide the infusion services in conjunction with a local pharmacy or infusion company that furnishes the fluids for the home health care nurse. The home health agency bills the patient only for the hands-on nursing services and the medical supplies associated with the therapy, but not for the pharmaceuticals. These are billed by the pharmacy or infusion company.

Home health agencies that are **Medicare-certified** (by the federal Health Care Financing Administration) must abide by the regulations set forth in the Health Insurance Manual (HIM) 11, as well as the **Medicare conditions of participation**. Such home health agencies undergo survey and licensure procedures, as do **Medicare-certified** Hospice providers, that other non-certified agencies do not face. Additionally, some agencies voluntarily seek and receive additional accreditation by professional groups such as the Joint Commission on Accreditation of Health Care Organizations (JCAHO). **Medicare-certified** agencies receive patients only upon the referral of a physician, and under the **Medicare conditions of participation** they are not permitted to advertise for patients.

Other types of home care providers, such as registries or private duty agencies, offer one or more home care services and often advertise for patients. These companies generally are not licensed by the states in which they do business; furthermore, in states where there is a certificate-of-need (CON) law or requirement, this type of agency operates without a CON. According to the State's licensing agency, fully 85 percent of the more than 100 companies listed in the local Yellow Pages in Atlanta, Georgia, as providing home health services do not have a state license. Similar situations are found in other locations throughout the country.

Home infusion or infusion therapy companies may or may not be covered under state licensure laws for providing hands on care. That is, some of the companies are unregulated, with the exception of their actual pharmacy.

Glossary of Terms

Activities of Daily Living (ADL) : The patient must be deficient in one of the following ADLs in order to qualify for Home Health Aide services under Medicare:

Mobility - Walking, or wheeling any distance on level surface.

Transferring - Moving between the bed and a chair or to the bed and a wheelchair.

Toileting - Getting to and from the toilet, getting on and off the toilet, and associated personal hygiene.

Eating - All major tasks of getting food into the body.

Dressing - Putting on and taking off all necessary items of clothing.

Acute Care : Skilled, medically necessary care provided by medical professionals, the goal of which is to restore health or ability to function.

Capitation : A system of prepayment for health care in which providers receive a flat monthly fee for agreeing to provide specified services to patients assigned to them for a contractual length of time. Unlike the traditional fee-for-service systems, capitated systems pay providers, either individually or collectively, the same amount per individual each month, in advance, regardless of how many times the individual uses their services.

Case Manager : A person or group that is assigned to help or make informed health care decisions for third party insurance carriers, employers, and consumers.

Custodial Care (Chore Services) : Non-skilled services that exceed the activities of daily living for the patient. These services are usually covered only through private payment, Title XIX Medicaid funding, or private insurance.

Diagnostic Related Groups (DRG) : The method by which hospitals are reimbursed under Medicare. It is based on the patients diagnosis, age, sex, treatment procedure, and discharge status.

Durable Medical Equipment (DME) : Physical medical equipment including oxygen, hospital beds, walkers, canes, potty chairs, etc.

Employer Mandate : The government (state or federal) requirement that employers provide certain benefits to their employees.

Fee-for-service : The traditional system of payment for health care in which a fee is charged for each service delivered.

Global Budget : A vague term that refers to having the government monitor or control private and public health care spending. In its most modest form, global budgeting means having the government establish a national spending target that can be adjusted from year to year. In its strongest form, the government sets a national spending ceiling and apportions the national budget to the states.

Health Alliance (Health Insurance Purchasing Cooperative) : A purchasing pool that would enable individuals and small businesses to spread the risk and purchase insurance at a lower rate than they would be able to individually.

Health Maintenance Organization (HMO) : A health plan that offers consumers for an annual or monthly fee a comprehensive range of benefits, usually with a small copayment collected at the time the service is rendered.

Staff Model HMO : An HMO in which physicians are on the staff and receive a salary.

Group/Network Model HMO : An arrangement in which the HMO rents the services of physicians for a straight per-capita rate (either per visit or monthly); the physician(s) also see patients on a fee-for-service basis.

Independent Physician Association Model (IPA) : HMO contracts with individual private practice physicians either directly or through a corporation of physicians who see HMO members in their own private practices for a pre-set fee.

Home Health Aide (Nursing Assistant) : A nonprofessional licensed employee who assists the patient with the activities of daily living and general household duties to ensure the patient's safety in the home.

Indemnity Plan : The traditional system of health insurance. Fee for services payments, usually having an annual deductible and copayment.

Infusion Therapy (I.V. Therapy) : Specialized intravenous treatment, prescribed for the patient by their physician, that allows the patient to take antibiotics or nutritional supplements through the use of I.V. technology in their home.

Infusion Therapy Agency : A private or corporately owned business that encompasses a pharmacy for mixing and dispensing intravenous medications, supplies, and that may also administer the medications. These agencies are generally not Medicare-certified providers and may or may not be licensed as a home care provider by the state in which they operate.

Managed Care : A collection of interdependent systems that integrate the financing and delivery of health care services by incorporating the following elements:

Arrangements with selected providers to furnish health care services to individuals for a set or reduced fee.

Specific standards for selecting providers.

Formal programs for ongoing quality assurance and utilization review.

Financial incentives for individuals to use plan providers and follow plan procedures.

Managed Competition : Not to be confused with managed care, this refers to the type of reform President Clinton advocated during the campaign to overhaul the country's health care system. It requires the government to regulate insurers so that no individual can be denied coverage and everyone buying the same plan in the same region would pay the same for it.

Medicaid : A matching Federal state program set up to provide medical aide for those unable to pay their own medical expenses.

Medicare : A Federal health insurance program for people 65 or older and certain disabled people, run by the Health Care Financing Administration.

Medicare-Certified Home Health Care : A federally and state licensed entity that provides services paid for under the Medicare program; may also provide Medicaid services.

Medical Social Work : Services that assist patients and their caregivers in locating and utilizing federal, state, and community services that assist them in improving their activities of daily living.

Occupational Therapy (OT) : Therapy that assists the patient in retaining and relearning motor skills to remain independent in the activities of daily living.

Physicians Plan of Treatment (PPOT) : The plan of treatment that the home health agency follows to care for its patients.

Physical Therapy (PT) : Therapy that assists the patient recovering from a debilitating injury. Therapists also teach the patient and the caregiver how and to what extent the patient should exercise in order to regain, or lessen additional loss of, physical ability.

Point of Service Plan (POS) : Encompasses characteristics of both HMOs and PPOs in an attempt to balance demand for cost containment and freedom of choice. POS plans use a network of contracted providers, and members chose a primary physician. Care received outside of the network is covered, but at a higher out of pocket cost to the patient.

Preferred Provider Organization (PPO) : Providers or panel of providers that have been selected and have contractual arrangements with payers on a discounted fee-for-service basis. Care received outside of the network is covered, but at a higher out of pocket cost to the patient.

Private Duty Nursing (Private Pay) : An individual or service providing around the clock or shift nursing, and chore services to a patient under contract with the patient or patients family.

Skilled Nursing : Intermittent care provided by a Registered Nurse (RN), or Licensed Practical Nurse (LPN), under a doctor's plan of treatment.

Speech Therapy (ST) : Therapy that assists the patient to relearn the ability to communicate vocally.

**TESTIMONY SUBMITTED BY THE AMERICAN ACADEMY OF PHYSICIAN
ASSISTANTS FOR THE RECORD**

Mr. Chairman:

The American Academy of Physician Assistants (AAPA) wishes to thank you for the opportunity to submit a statement for the hearing record regarding changes to Medicare in the Health Security Act. AAPA has three major concerns to raise with you concerning access to quality, cost-effective health care for the elderly:

- Health reform should pay special attention to the needs of underserved populations in both rural and urban areas;
- Reform of the health care workforce should include a funding mechanism to provide for the education of physician assistants (PAs);
- Medicare should cover physician assistant services in all practice settings at a uniform rate of reimbursement.

ACCESS FOR MEDICARE PATIENTS

A very large proportion of Medicare eligible citizens live in rural areas. Many of them also live in poverty. Their declining health status combines with the lack of health care facilities and the lack of health care providers to make their access to health care very problematical regardless of the fact that they have coverage. Medicare reimbursement rates which do not reflect the actual cost of care mean that many small, rural hospitals with very high proportions of Medicare patients are on the edge of financial disaster. They do not have the patient base to shift costs and make up for these losses. Further cuts in reimbursement rates would push them over the edge.

In 1977, congress passed the rural health clinics program to try to increase access to health care in rural, underserved areas through the utilization of physician assistants, nurse practitioners (NPs), and certified nurse midwives (CNMs). These clinics are eligible for cost-based reimbursement from Medicare and Medicaid, rather than the traditional fee-for-service. We believe the combination of relying on PAs, NPs, and CNMs as a primary source of health care delivery and providing cost-based Medicare and Medicaid reimbursement rather than fee-for-service is what makes health care delivery viable in rural areas. Many rural medical practices serve over 50% Medicare and Medicaid patients. They could not survive strictly on the traditional fee-for-service payment model.

Over the past two years, there has been considerable interest in the rural health clinics program. Much of that interest is being driven by rural hospitals. By establishing hospital owned and operated rural health clinics, the hospitals establish a strong, cost-effective primary care presence in the community. Continuation of the cost-based payment approach to rural

health clinics is essential to the continuation and growth of this program to provide meaningful access to medically underserved populations. **The cost-based approach to payment and reliance on physician assistants or nurse practitioners is what makes these clinics able to maintain their economic viability. It is the most appropriate method of payment for these practices and it should be continued.**

Because of the success of this program in meeting the needs of the elderly in rural America, **the AAPA strongly recommends that the Congress establish a similar program, with similar requirements to utilize PAs, NPs and CNMs, in urban underserved areas as well.**

PAs have an excellent record of practicing where they are needed. Approximately 50% of PAs are in primary care and 17% are serving populations in small, rural towns of under 10,000. PA education programs are actively seeking to recruit and train students from minority and disadvantaged backgrounds. There is evidence that many of these students do return to practice in their home communities. It seems both logical and productive to provide incentives to enable cost-effective, highly qualified practitioners to establish practices among populations who most need the services. Urban health clinics, as well as rural health clinics, could be the means to this end.

CHANGES IN GRADUATE MEDICAL EDUCATION

The health security act proposes to change the health care workforce by changing the way health education is financed. By the year 1998, 55% of physician residencies must be in primary care and residency programs will receive funding based on their adherence to these requirements. Clearly the change in funding for graduate medical education is intended to increase the number of primary care physicians and decrease the number of specialists. This approach to restructuring graduate medical education overlooks two facts:

- 1) The Health Security Act recognizes that the health care needs of the American people are best served by the team approach to health care rather than relying on only one type of health care provider. However, the funding source for nonphysician providers is discretionary and therefore uncertain, whereas the funding for physician training is guaranteed.
- 2) The decrease in specialty residencies will not necessarily result in a decrease in the number of patients requiring specialty services. Hospitals will be looking to PAs to replace lost residents and to serve the needs of these patients.

In order to meet the needs of health care reform, the number of physician assistants should double by the end of this decade. There are currently 58 accredited PA programs and approximately 30 more in various stages of planning and development. But there is no way that programs can expand fast enough, recruit and train faculty, and recruit appropriate students without a guaranteed, uninterrupted and adequate funding source.

In FY94, for the first time in over a decade, PA program funding received a modest increase from the Congress. While this appropriation of \$6.554 million is headed in the right direction, it is frankly not enough to meet the needs of the anticipated health care reform. Discretionary program funding limits have been frozen for the next five years, and there are repeated efforts by groups in both the House and Senate to slash discretionary spending even further.

The Clinton bill provides for a portion of GME money to be directed to nurse education. The Congress should recognize the important contribution of other health professionals who provide physician services and dedicate a percentage of GME funds to physician assistant education also.

MEDICARE COVERAGE AND REIMBURSEMENT

The lack for Medicare coverage for PAs in all practice settings has been a serious barrier to practice, hindering the full utilization of PAs as part of the health care team and denying access to Medicare patients. We are very pleased that H.R.3600 begins to address this problem by providing Medicare coverage for PAs in all practice settings. However, as written, Medicare would continue its present reimbursement structure for physician services provided by PAs. This structure provides for rates that vary according to service and practice setting and have no methodological justification. PAs support a uniform rate of payment which is based on principles established by the Physician Payment Review Commission. Payment rates should be based on the work component, overhead costs, and malpractice costs.

Additionally, PAs working in rural and medically underserved areas should receive the same bonus payments provided for physicians and for exactly the same reason--to provide an incentive for all qualified health professionals to practice where there is the greatest need for increased access.

Finally, Medicare reimbursement should recognize current practice realities and allow a more flexible definition of what constitutes an "employee." Under current law, reimbursement for PA services is dependent on the PA being an employee of the practice in question.

The definition of "employee" should be expanded to include any independent contractor arrangement, and an employer status should be determined in accordance with the law of the state in which the services are performed.

In conclusion, AAPA would like to emphasize the following points with regard to Medicare changes in the health security act:

- 1) Medicare payment rates should not disadvantage hospitals and providers in rural areas;
- 2) Rural health clinics should continue to be reimbursed on a cost basis;
- 3) The Congress should establish an urban health clinics program following the same pattern as the rural health clinics;
- 4) A percentage of graduate medical education money should be directed to PA education;
- 5) PAs should be covered by Medicare in all practice settings at a uniform reimbursement rate;
- 6) PAs should be eligible for the same bonus payments as physicians in underserved areas;
- 7) Reimbursement should not be tied to outmoded practice patterns and relationships. Employer-employee status should be determined by the laws of the state in which the service is performed.

Thank you very much for this opportunity to have our testimony considered as a part of the hearing record.



AMERICAN ASSOCIATION FOR CLINICAL CHEMISTRY, INC.



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STATEMENT OF THE
AMERICAN ASSOCIATION FOR CLINICAL CHEMISTRY
SUBMITTED TO
HOUSE SUBCOMMITTEE ON HEALTH

The American Association for Clinical Chemistry, Inc. (AACC) welcomes the opportunity to comment on the Administration's health care reform legislation. Representing nearly 11,000 professional laboratory scientists, AACC supports Administration and congressional efforts to reform our health care system. We believe that comprehensive reform is necessary to meet our nation's goal of providing quality, affordable health care services to all our citizens. Though we are still evaluating the President's Health Security Act, we have identified a number of areas, such as the Medical copayment and competitive bidding provisions, that may adversely affect the quality and availability of clinical laboratory testing.

In 1984, Congress passed legislation replacing the previous "reasonable charge" reimbursement system with a laboratory fee schedule that required "mandatory assignment" for all diagnostic laboratory services provided to Medicare patients. These changes resulted in lower fees for laboratories. In exchange for laboratorian support, Congress agreed to eliminate the 20 percent copayment provision for laboratory services. This was a reasonable compromise, since copayment billing and collection costs often exceed the patient's financial responsibility. The Administration plan would now repudiate this agreement.

The reinstitution of the Medicare copayment for laboratory services would also place an additional financial burden on laboratories. Between 1984-1990, the national limitation amount (used to reimburse laboratories) was cut four times, from 115 percent of the median to 88 percent--resulting in more than \$3 billion in fee cuts. This trend continued under the FY94 budget agreement, which will cut lab reimbursement to 76 percent of the median (over three years) and eliminate the inflationary update for two years--cutting lab payments by an additional \$3.3 billion. This cut represented 14 percent of all Part B reductions, while laboratory services accounted for only 4.5 percent of Part B expenditures.

At the same time laboratories are being required to implement new, extremely costly federal regulations, such as CLIA '88 and the OSHA bloodborne pathogen standard. According to government estimates, these two rules alone will cost the laboratory community \$3 billion to implement. In the case of CLIA, the labs are paying all the federal costs, too, through user fees. Though AACC supports efforts to improve the quality of diagnostic testing and strengthen worker protections, complying with these regulations is expensive. These additional costs, as well as the proposed cuts, will make it difficult for some facilities, especially for those in rural and urban areas with large Medicare populations, to continue testing. Therefore, AACC recommends that the Medicare coinsurance provision be deleted from the President's proposal.

The policy of the American Association for Clinical Chemistry, Inc., is that only the President, President Elect, Past President, Secretary, Treasurer, Executive Vice President, and the Association's Legal Counsel may make official statements on behalf of the Association. This limitation does not apply to the conduct of routine business transactions.

AACC also strongly opposes the Administration's recommendation to institute a competitive bidding system for laboratory services. This proposal, which was advanced by the Reagan and Bush Administrations, would permit HHS to seek "bids" from laboratories performing clinical diagnostic testing. Only facilities selected on the basis of price would win the right to perform tests and bill for all testing within a specified region. AACC is concerned that the establishment of a winner-take-all competitive bidding system may ultimately restrict competition, forcing many small, special service laboratories out of business.

AACC is further troubled by a related provision, which would permit the Secretary to reduce lab payments by up to 10 percent if, upon review, a competitive bidding system would not generate a 10 percent savings. AACC opposes both the granting of this authority to the Secretary, as well as the proposal of still another cut on top of previous reductions.

In its place, we recommend that Congress enact a direct billing requirement, prohibiting physicians from "marking-up" and billing for laboratory tests they refer to other labs and do not perform themselves. Though Medicare currently prohibits this practice, it is still allowed for private payors in non-direct billing states. In these states, physicians have a financial incentive to order additional, unnecessary testing, contributing to the overutilization of diagnostic procedures. Often this test ordering pattern has a spillover effect on Medicare test utilization, resulting in needless tests and depleting the Medicare budget.

A study performed by the Center for Health Policy Studies (CHPS) indicated that physicians order 6.5 percent more tests per Medicare enrollee in non-direct billing states. AACC recommends that a direct billing requirement be added to the budget package in place of the coinsurance provision. A comprehensive direct billing requirement could reduce health care costs for the patient, the insurer and the Medicare program.

By way of background, AACC is the principal association of clinical chemists--professional laboratory scientists--including MDs, PhDs and medical technologists. Clinical chemists develop and use chemical concepts, procedures, techniques and instrumentation for assessing and monitoring health status. The AACC represents 11,000 clinical chemists working in hospitals, independent laboratories and industries nationwide. The AACC's objectives are to further the public interest in the field of clinical chemistry, promote research and educational activities and help maintain high professional standards.

We look forward to working with the Chairman and the subcommittee in resolving our current health care crisis. If you have any questions, please call Lemuel J. Bowie, President, at (708) 570-2783 or Pamela A. Nash, Director of Professional, Government and Membership Affairs at (202) 857-0717.

**TESTIMONY OF A. PETER LUNDIN, M.D., PRESIDENT
AMERICAN ASSOCIATION OF KIDNEY PATIENTS**

Mr. Chairman and Members of the Subcommittee on Health I am pleased to submit a written statement on behalf of the American Association of Kidney Patients (AAKP). My name is Peter Lundin. I am President of AAKP and a practicing Nephrologist. Moreover, I have been a dialysis patient for 25 years and have had a kidney transplant for the past two years.

I want to preface my remarks by emphasizing that the membership of AAKP is concerned about the role the Medicare End-Stage Renal Disease Program (ESRD) will play in the Health Security Act. As a National Organization of kidney patients, it is our hope that Congress will insure the continuation of the very successful ESRD program, which has covered the expenses of dialysis, transplantation, physician services and immunosuppressive drugs for more than 20 years. As you know, dialysis is unique among high-tech medical therapies. Without dialysis death will certainly occur, however with dialysis treatments, patients can expect long term survival allowing them to lead normal, healthy lives.

There are several points we wish to make to the Subcommittee:

1. First, AAKP hopes that the Medicare ESRD Program under the Clinton Plan will continue in the same capacity as it is currently legislated. We are concerned that requiring patients to leave the Medicare Program and enter Health Alliance Plans may lead to difficulties in achieving the current level of care. It is our belief that eliminating the Medicare ESRD Program, before a complete analysis of how the Clinton Plan incorporates dialysis and transplant care, could be detrimental to the more than 150,000 patients.

2. We are concerned that quality assurance levels will be lower for patients choosing a Health Alliance Plan over Medicare. As you are well aware, the Health Care Finance Administration (HCFA) currently sets certain quality standards criteria that are reviewed in the dialysis facilities by the ESRD Networks, thus assuring adequate patient care. We desire that the Clinton Plan include the same quality assurance guidelines that are currently built into the Medicare Program and these guidelines become mandatory for the Alliances. ESRD Networks should be required to track Medicare and Alliance kidney patients.

3. Discrimination is also a worry to patients. AAKP is concerned that Alliances will not be willing to enroll kidney patients even though they are prohibited from discrimination under the Clinton Plan. We are concerned that if the Plan's risk adjusted premium is not high enough to cover the cost of dialysis and/or transplantation, the plan will find ways to avoid covering kidney patients.

We also are concerned that Alliance participants will have higher premium costs than Medicare participants, thus causing significant financial burdens to patients.

4. AAKP is well aware that the Clinton Plan emphasizes managed care and we wish to bring to your attention the numerous complaints we currently receive from kidney patients enrolled in HMO's. Complaints include difficulties in securing transplant services outside the HMO and the ability to choose dialysis facilities and physicians. We hope you will address these issues when you consider your health care reform legislation.

5. Lastly, AAKP supports various items in the Clinton Plan and we are grateful for their inclusion. The expanded outpatient prescription drug coverage is very important and helpful to kidney patients who currently spend an exorbitant amount of out-of-pocket dollars on medications. We also support home and community based long term care grant programs to the states, as it will assist family members with the difficulties of both the financial and emotional burdens of health care for a loved one. We are also very appreciative of the Clinton Plan cap on out of pocket costs for individuals in the Alliance Plans and respectively suggest that such a cap also be instituted in Medicare.

We appreciate the opportunity to address the Subcommittee via written testimony and will be happy to respond to any questions or comments any Member may have.
Thank you.

STATEMENT OF JOYCE H. LYBRAND, MT(AMT), PRESIDENT,
AMERICAN MEDICAL TECHNOLOGISTS
TO THE SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS & MEANS
UNITED STATES HOUSE OF REPRESENTATIVES
REGARDING MEDICARE CUTS
INCLUDED IN THE HEALTH SECURITY ACT

On behalf of American Medical Technologists (AMT), I am pleased to have this opportunity to share with the subcommittee our views on the Medicare cuts included in President Clinton's Health Security Act, and their impact on the clinical laboratory industry. AMT, incorporated in 1939, is a national certifying agency and registry for over 20,000 medical laboratory personnel, medical assistants and dental assistants across the United States.

AMT is concerned with two specific provisions included in the President's health reform package: the reimposition of a 20 percent coinsurance for laboratory services, and the establishment of a competitive bidding procedure for the acquisition of laboratory services.

If enacted, these provisions would effect a 20 to 25 percent real reduction in reimbursement levels for clinical laboratory services, without appreciably reducing lab testing utilization. It is also important to note that this cut comes on the heels of a 14 percent reduction approved by Congress in August as part of the Omnibus Budget Reconciliation Act of 1993. These reductions would constitute a total decrease of nearly 40 percent in Medicare payments to laboratories. These cuts will threaten the ability of laboratories to provide high quality services; to employ the most qualified individuals; and to ensure that all Medicare beneficiaries enjoy access to necessary laboratory services. In addition, at a time when our nation faces a weak job market, these reductions could result in a loss of jobs for qualified health care professionals.

Also at this time, although it is not currently in the President's health plan, we would like to extend our support to enactment of a direct billing requirement for laboratory services.

TWENTY PERCENT COINSURANCE FOR LABORATORY SERVICES

AMT strongly opposes the reinstitution of a 20 percent coinsurance for laboratory services provided to Medicare beneficiaries.

This initiative would require Medicare beneficiaries to make a 20 percent copayment for each laboratory test. To produce the additional invoice covering the coinsurance alone would cost between \$3.00 and \$5.00, which in many cases exceeds the amount being billed. Because laboratory coinsurance is difficult to collect, it has been suggested that in many cases, laboratories would have to write off 20 to 50 percent of the billed amounts. It is estimated that reenactment of coinsurance would result in reimbursement reductions of at least 15 percent for some laboratories. And finally, this proposal would shift \$7 billion in costs to senior citizens and state governments.

It is for these reasons that Congress adopted the current Medicare fee schedule methodology in 1984, with the approval of the Health Care Financing Administration (HCFA) and the laboratory industry, and eliminated the coinsurance requirement. Unlike other forms of coinsurance, laboratory coinsurance does not affect utilization, a fact recognized in a 1990 report prepared by the Congressional Budget Office (CBO), because physicians, not patients, decide whether to order laboratory tests.

In sum, lab coinsurance is a misguided and short-sighted savings initiative because it hurts senior citizens and laboratories without sending price signals to the right places.

ESTABLISHMENT OF A COMPETITIVE BIDDING REQUIREMENT

Competitive bidding will also have an adverse affect on clinical laboratory services.

President Clinton has been pushing for every American to have the right to choose his or her own doctor. Yet the Health Security Act includes a plan to establish a competitive bidding procedure for the acquisition of laboratory services. This "winner take all" bidding plan for clinical laboratory services would eliminate consumer choice and permit only one laboratory to provide Medicare reimbursed laboratory services in each area. It is our belief that doctors and their patients should be given a choice of qualified laboratories. In addition, the plan is required to lower expenditures by 10 percent per year or other reductions in reimbursement would be triggered.

In past years, Congress opposed implementation of a competitive bidding proposal offered by HCFA because of concerns of its workability. There is the likelihood that providers will submit "low ball" bids in order to obtain the contract, but then be unable to afford to provide the services at the bid-winning price. As a result, quality is compromised while the patients' health is put at risk.

The laboratory industry already is highly competitive. The short-term savings a competitive bidding program ostensibly would provide are illusory. In the end, quality of care, access to services, and competition would all suffer.

DIRECT BILLING

AMT supports the inclusion of a direct billing requirement for laboratory services as a more cost-conscious and efficient system for Medicare reimbursement.

We have in the past and continue to support direct billing of laboratory services, a process by which the laboratory that performs the testing also bill's the patient or insurer for those services, rather than the physician ordering the test. Under Medicare law, the laboratory performing the test must bill the Program directly, avoiding a mark-up of the testing fee by the physician, which happens in many cases. Enactment of a direct billing requirement would extend the benefits of the Medicare rule to private payers and patients.

An independent study has shown that if the Medicare direct billing requirement were extended to all payers, there would be a reduction of utilization of laboratory testing and lower costs, resulting in an annual savings to the health care system of between \$2.4 and \$3.2 billion.

Thank you for this opportunity to share our comments with the subcommittee. We urge you and your colleagues in the House of Representatives to oppose the coinsurance and competitive bidding proposals in all health care reform legislation and ask that you support the enactment of a direct billing requirement.

**TESTIMONY OF REX B. CONN, M.D.
AMERICAN SOCIETY OF CLINICAL PATHOLOGISTS**

Mr. Chairman, I am Rex B. Conn, M.D., President of the American Society of Clinical Pathologists. I appreciate the opportunity to address the Ways and Means Subcommittee on Health today concerning issues relating to Medicare changes in the President's health care reform proposal.

The American Society of Clinical Pathologists (ASCP) is a nonprofit medical specialty society organized for educational and scientific purposes. Its membership numbers more than 66,000 board certified pathologists, other physicians, clinical scientists and certified medical technologists and technicians. These professionals recognize the Society as the principal source of continuing education in pathology and as the leading organization for the certification of laboratory personnel.

ASCP recognizes the importance of reforming our nation's health care system, and containing the skyrocketing costs of medical care. The ASCP believes this can be accomplished without decreasing access to care and without decreasing quality of care.

Drastic Reductions in Medicare Affect Quality and Patient Access to Care

The ASCP is concerned that further cuts by Congress to clinical laboratory Medicare reimbursement under health system reform may result in decreased access to care, may decrease quality of care, and may hamper the ability for laboratories to attract and retain qualified laboratory personnel. These proposed cuts are likely to impact rural and underserved areas the hardest.

Patient safety must be foremost on the minds of Congress, and we must remain committed to insuring patient safety. The ASCP is concerned that clinical labs may be singled out for an unfair and disproportionate share of the Medicare fee cuts.

Laboratories have repeatedly seen cuts in reimbursement during the last eight years. These cuts included a \$1.2 billion cut in the Omnibus Budget Reconciliation Act of 1990 (OBRA '90) and in OBRA '93, labs saw a freeze in the inflation adjustment for 2 years, as well as a reduction of the Medicare fee cap from 88% to 76% of the

median. Under the proposed Clinton health reform plan, labs would see an automatic 10% reimbursement reduction if competitive bidding did not reduce the fees by at least that amount.

The proposed cuts, combined with current efforts to comply with such regulatory requirements as those promulgated by the Occupational Safety and Health Administration (implemented to ensure safe work environments) may cause decreased access to care when labs in rural communities are forced out of business. Clinical labs account for only 4.5 percent of Medicare expenditures, but are being asked to absorb nearly 20 percent of the Medicare Part B cuts. While large reference labs may be able to absorb these losses, small labs will likely have great difficulty and be forced to close their doors.

The ASCP hopes that as Congress reviews Medicare issues under health system reform, in particular those affecting clinical laboratories, they keep in mind possible adverse outcomes to quality and access to medical care.

Direct Billing as a Means of Medicare Cost Reduction

Quality health care depends largely upon the availability of reliable information derived from diagnostic or screening procedures, such as that provided by laboratory tests. Yet, despite the enactment last year of stringent quality control standards for clinical laboratories, questionable financial incentives which influence selection of a laboratory and of laboratory tests continue to undermine the quality of health care. Fundamental changes in the delivery of laboratory services are necessary. If laboratory reform efforts, begun with the passage of The Clinical Laboratory Improvement Amendments of 1988, are to truly result in better patient care and more reasonable consumer costs, we believe that enactment of a direct billing requirement is essential. According to a recent study by the Center for Health Policy Studies, (prepared by Zachary Dyckman, Ph.D. for the American Clinical Laboratory Association) a national direct billing law would save between \$2.4 and \$3.2 billion dollars a year.

We believe that direct billing will remove the referring physician's potential for financial gain in the selection of laboratory tests, and will result in improved health care as well as decreased utilization. Tests ordered solely on the basis of medical necessity will be provided by laboratories selected on the basis of performance rather

than on the physician's realization of increased revenue. The ultimate beneficiary of this requirement is the patient. Therefore, we urge Congress to consider reviewing the merits of a national direct billing law as a method of cost containment under health system reform.

Competitive Bidding Raises Concerns

It is important to consider all aspects, favorable and unfavorable, of paying for laboratory services through a competitive bidding process. Clinical laboratories are increasingly involved in point of care testing, which cannot be centralized and which directly improves patient care. In most hospitals and clinical laboratories, there must be maintained a certain ability for rapid reporting. This requires the maintenance of basic instrumentation and trained personnel. The same procedures can be used for all routine testing, rather than sending specimens to a centralized laboratory.

Congress has blocked implementation of competitive bidding proposals offered by HCFA in the past, because of concerns about its workability. Under the President's Competitive bidding proposal, it appears to establish a "winner take all" competitive bidding plan for laboratory services. In a winner take all situation, it is unclear what laboratories will still be operational and able to bid during the second year.

Such a competitive bidding system fails to recognize that laboratory services are not a commodity, they are a health care service. Physicians, therefore, often have strong preferences among laboratories because of quality and service differences. A competitive bidding plan such as that envisioned by the President's plan would remove the ability of physicians to choose the laboratory they believe best serves the needs of their patients.

Graduate Medical Education Reform Should Address Pathology Manpower Shortage

ASCP recognizes the importance of insuring an adequate supply of medical generalists, and the need to plan for the future health care requirements of our country. According to a survey by the American Medical Association, there were 2,863 vacancies in residency training positions for internal medicine, family practice and pediatrics in 1991. These remained unfilled because of a lack of applicants.

However, we hope efforts to improve the shortage in medical generalists will not exacerbate the growing problem of recruitment and retention of pathology residents.

The number of approved pathology training programs has steadily declined because of a lack of applicants, and the specialty is now losing an average of 1.87 pathologists a day because of retirements and deaths. Recent studies predict an overall shortage of pathologists to fill positions in both medical school departments and community pathology practices. In respect to community practice alone, it is anticipated that less than 400 new pathologists a year will be available to fill an anticipated 600 openings.

With the increased emphasis under proposed health reform proposals placed on nurse practitioners and physician assistants, who do not possess an in-depth knowledge in laboratory medicine, they will be more and more reliant on pathologists for the interpretation of clinical results.

We would encourage you to consider the pathology manpower shortage when discussing possible reductions in federal payment for Graduate Medical Education specialties. Other concerns we have include:

- Ensuring accurate data systems for measuring physician supply across specialties.
- Establishing appropriate physician representation on any national board designed to determine adequate number of specialty positions and to allocate those specialty positions to training facilities.

On behalf of ASCP, I would like to thank you for the opportunity to share our concerns and suggestions with you today. I hope you and your staff will contact us for any assistance that we can provide to you.

**TESTIMONY OF THE
GREATER NEW YORK HOSPITAL ASSOCIATION
BEFORE THE
HOUSE WAYS AND MEANS SUBCOMMITTEE ON HEALTH
ON THE
PRESIDENT'S HEALTH CARE REFORM PROPOSALS:
CHANGES TO THE MEDICARE PROGRAM**

November 23, 1993

My name is Kenneth E. Raske and I am President of the Greater New York Hospital Association (GNYHA), which represents 164 hospitals and nursing homes in New York City and its surrounding communities. I am grateful for the opportunity to present testimony on GNYHA's position on the Medicare changes proposed in President Clinton's Health Security Act and the effect of these changes on our member institutions.

In my testimony, I will address several topics germane to the issue before the Subcommittee today: I will profile GNYHA's membership because, for a variety of reasons, our hospitals are less prepared for health reform than many of their counterparts nationally; I will provide the results of GNYHA's preliminary analysis assessing the revenue impact of the Administration's plan on New York City hospitals; I will discuss how the health reform plan, by itself, does not address many of the broader social problems that have long been addressed by urban and inner-city hospitals; and I will discuss the principles for graduate medical education reform that we believe, if followed, will truly improve our health delivery system while preserving the excellence of our nation's teaching institutions.

PROFILE OF GNYHA'S MEMBERSHIP

As the debate on health care reform begins and Medicare changes are contemplated, GNYHA believes that it is important to understand the unique environment that characterizes the health care delivery system in the New York City area. Outlined below are a number of factors that we believe need to be seriously considered when evaluating the effectiveness of any health care reform proposal and the real-life effects of Medicare reimbursement changes on the health of New York City's communities and providers.

- **New York Hospitals Cannot Shift Costs:** Inpatient hospital rates in New York State are set by the State government; therefore, our members have no control over what they charge patients for inpatient care. This government rate-setting system has had the effect of constraining hospital budgets for many years. While this may have helped keep hospital inflation in check, it has also had the effect of depleting our hospitals' capital reserves.

In addition, it has meant that Medicare and Medicaid cuts over the years, which we have seen repeatedly, including record cuts in this year's deficit reduction bill, have resulted in real reductions for New York hospitals. In other states where hospitals control their own charges, cuts in government reimbursements can be made up through increases in rates charged to private insurance companies. In New York, where the government sets the rates, hospitals do not have this option. Therefore, all of the recent cuts have meant real cuts.

The impact of all of this can be demonstrated by comparing the bottom lines of New York hospitals with those of hospitals nationwide. The New York State Department of Health recently reported that New York City hospitals, public and private, had an aggregate bottom-line margin in 1992 of -1.1%. Our voluntary hospitals alone had an aggregate bottom-line margin of less than .1%. Compare this with a nationwide average of 5.2% and you see that we are in a profoundly different situation than hospitals elsewhere.

- **New York Hospitals Rely on Public Programs:** New York hospitals are much more dependent on public insurance programs, such as Medicare and Medicaid, than hospitals in any other state in the country. We are more reliant on Medicare because our population is somewhat older than the national average. We also have a very heavy concentration of physician training programs in New York, training fully 15% of all medical residents nationwide. Because

Medicare contributes to the costs of training residents through direct and indirect medical education reimbursements, our Medicare payments are higher as a proportion of revenue than hospitals elsewhere.

As far as Medicaid is concerned, New York State's Medicaid program is relatively generous when compared to any other Medicaid program in the country. On average, over 19% of all hospital expenses in New York State are covered by Medicaid. This is a much higher proportion than anywhere else, and reflects New York's commitment to Medicaid. As a result of this commitment to health care coverage for the poor, New York's rate of uninsured is lower than the national average.

- **New York Hospitals Battle Particularly Severe Epidemics:** The problems that plague American society are particularly pronounced in urban areas like New York City--violence, substance abuse and homelessness, as well as public health epidemics. Twenty percent of all AIDS cases nationwide are treated in New York City. We also see more cases of tuberculosis than the cities of Atlanta, Boston, Chicago, Houston, Los Angeles, Miami, and San Francisco combined. As a result, New York hospitals treat sicker and costlier patients than hospitals elsewhere and, therefore, rely heavily on Medicare disproportionate share funds to help cover these costs.

IMPACT OF PRESIDENT'S HEALTH CARE REFORM PLAN ON NEW YORK CITY

GNYHA does not want to diminish the importance of achieving universal coverage, and will advocate strongly to see it accomplished. Our concern with the Clinton plan from a New York point of view is the financing of new spending. Increased spending is financed through draconian cuts in Medicare and Medicaid. The effect of this financing mechanism is to shift funds from areas of the country with a strong commitment to health care, as evidenced by per capita Medicaid and Medicare spending, to areas of the country with traditionally weak commitments and, therefore, much higher rates of uninsured citizens.

Our preliminary analysis illustrates this and indicates that if the plan were financed as currently proposed, the hospitals in New York City would experience net revenue reductions of such magnitude that many would not be able to sustain their current level of operations. Perversely, the hospitals most at risk are those serving high concentrations of patients whose health insurance coverage is publicly financed.

The theory underlying the health reform proposal is that incremental revenue derived from the provision of health insurance coverage for the currently uninsured will offset Medicare and Medicaid payment reductions, such that hospitals and other health care providers will be held harmless from major funding dislocations caused by shifts in the financing of health care coverage under health reform. While this may or may not be true on a nationwide basis, it is clearly not the case in certain regions of the country, particularly large urban centers that, heretofore, have attempted to ensure access to health care services for all who are in need.

Indeed, hospitals in New York City might expect to realize \$8 billion in new revenue from 1996 through 2000 from the provision of universal health insurance coverage. Yet, this would leave a revenue gap of \$4 billion, since the value of the expected Medicaid and Medicare payment reductions is about \$12 billion. A five-year loss of \$4 billion, or \$800 million on an average annual basis, representing over 4% of gross revenues, could not be sustained by the hospitals in New York City, as they are currently operating with virtually no financial cushion.

In many other areas of the country, a revenue contraction of 4% would squeeze a hospital's profit margin, such that a loss of this magnitude would inhibit the institution's ability to invest in capital projects and innovative programs, but it would not put the hospital out of business. New York's voluntary hospitals, on the other hand, are operating essentially at break even, such that a 4% revenue contraction would force the closure of certain programs or institutions.

I have provided the Subcommittee with a complete copy of GNYHA's preliminary analysis and have attached a summary table to this statement. However, the effect of some of the more

damaging cuts is worth further elaboration here.

- **Reduction of hospital market basket update by 2% from 1997-2000:** There is no programmatic rationale for this cut; it is an arbitrary price reduction proposed solely for the purpose of achieving Federal budget savings through the Medicare program. Given the fact that hospitals in New York have no profit margin and cannot shift the cost of care for any class of patients onto other payers, as well as the fact that we have such a large Medicare patient load, this cut will directly affect the bottom lines of New York hospitals.
- **Reduction of indirect medical education adjustment to 3% starting in 1996:** IME funding is provided to teaching hospitals in recognition of the fact that their service costs are higher than those found in non-teaching hospitals for reasons unrelated to the direct cost of graduate medical education. The proposal to cut the level of IME funding by 60% is not based upon empirical studies justifying a lower level of funding.

Furthermore, White House staff have suggested that non-Medicare payers will pick up the slack for hospitals, as evidenced by their statement to us that monies received by hospitals from the two proposed medical education pools were assumed to be incremental to any funds currently received for IME. We who operate in New York believe that pool distributions will not constitute incremental funding. Rather, it is more likely that non-Medicare payers will eliminate any GME funding currently built into hospital payment rates that will be paid in the future through the pools, especially since the value of GME can be identified easily in the hospital reimbursement rates.

- **Averaging of direct medical education payment rate:** Whereas the Medicare program currently reimburses hospitals for the direct cost of graduate medical education through a prospectively determined, hospital-specific per resident amount, the Clinton health reform plan would change this policy to one that reimburses hospitals according to a regionally-adjusted national average per resident amount. There are no program savings attached to this proposal; it merely redistributes money among the nation's teaching hospitals.

There is no justification for reimbursing hospitals according to a national price, because the cost of direct GME varies among hospitals for legitimate reasons. These variations have been audited thoroughly and approved by HCFA, such that a move to average pricing would have the effect of arbitrarily underpaying some hospitals while overpaying other hospitals. For example, teaching hospitals in inner cities usually have higher resident supervision costs than hospitals in more affluent areas, because supervising physicians in more affluent areas generally have greater Part B billing opportunities, which reduces their need for direct compensation for teaching activities.

Because they serve an inner city population, many teaching hospitals in New York City would be affected quite adversely by an averaging of the Medicare per resident amount. We estimate that area hospitals would lose a minimum of \$600 million from 1996 through 2000, irrespective of other changes in GME policy, such as a reduction in the number of residents.

- **Capital Reimbursement Reductions:** The Administration's proposal regarding capital has three elements: (1) it would extend the reduction to the Federal rate promulgated in OBRA 1993 to account for past overbudgeting and would similarly discount the hospital-specific portion of the fully-prospective rate paid to low cost hospitals during the transition to the capital PPS; (2) it would give the Secretary discretion to set the annual capital PPS update factor; and (3) it would allow the Secretary to reduce the update factor by up to 100% in order to reduce the aggregate level of Medicare capital spending to make up for perceived industry overspending prior to 1992.

The third element of the proposal is especially troublesome. The credibility of any Federal program is certainly challenged by the notion of changing any policy retroactively. It is highly unfair and inappropriate to reduce prospectively payments for costs incurred in the past, which, therefore, cannot be modified to fit the new payment schedule.

The only way that hospitals could fulfill their capital obligations incurred in the past with current payments that did not keep pace with inflation would be to restrict new capital investment. Yet, it is not axiomatic that new investment is either unnecessary or undesirable, particularly since hospitals are currently engaged in upgrading and expanding information systems in the context of implementing ambitious cost-containment and quality assurance programs under health care reform.

More importantly, however, the elimination of an inflation factor due to perceived past overspending would affect *all* hospitals, including New York hospitals, whose spending is rigorously monitored through the New York State Certificate of Need process and whose past capital investment has lagged that of other hospitals nationwide due to the recession of the 1970s as well as a State moratorium on capital investment during the early-1980s, which was imposed in order to compel a contraction of the industry. It is bad enough that the capital PPS was promulgated at a time when New York hospitals were playing catch-up in terms of needed capital formation, because these hospitals will be automatically underpaid¹. To arbitrarily reduce payments for new capital investment in conjunction with underpaying high cost hospitals during the early years of the capital PPS would be have the undesirable effect of shutting down certain needed projects.

• **Reduction in Medicare Disproportionate Share Adjustment:** The Administration's proposal would curtail sharply the level of assistance to hospitals serving a disproportionate share of indigent Medicare patients. Whereas in the past, the Program would use a hospital's share of Medicaid and disabled patients as a proxy for disproportionate share need, in the future, the Program would utilize only the disabled patient count as a proxy for an indigent Medicare patient load.

HCFA officials have stated that this proposal was based upon a new regression analysis, which showed that the SSI population was a better predictor of the level of indigent Medicare patients. However, to our knowledge, this analysis has neither been verified independently nor presented to the public for review.

While there is a common belief that a portion of Medicare DSH payments was intended to reimburse hospitals for the cost of uncompensated care--which, ostensibly, would no longer be necessary in the context of universal coverage--an explicit link between the Medicaid portion of the DSH formula and uncompensated care has never been promulgated, such that the wholesale elimination of the Medicaid proxy from the formula would be arbitrary and capricious. In fact, however, hospitals will continue to provide uncompensated care, especially in poor communities, because every insurance plan would be required to have a cost-sharing provision.

• **Other price reductions:** Price reductions were proposed in relation to several other Part A and Part B services. We believe it is extremely inappropriate for Medicare to pay less than cost for any service, especially in the context of an expansion of managed care, because the reduction in service utilization that generally accompanies a shift of enrollment into managed care plans places any institution more at risk for underpayment of its fixed costs. Thus, particularly in the context of President Clinton's health reform proposal which relies heavily upon an expansion of managed care enrollment, the Medicare program should pay particular attention to ensuring that its payments cover the cost of services to its beneficiaries.

PRINCIPLES OF GRADUATE MEDICAL EDUCATION REFORM

As I mentioned earlier in my testimony, New York City hospitals train fully fifteen percent of

¹ Hospitals entering the high cost phase of the capital cycle at the inception of the capital PPS are grossly disadvantaged, because rather than receiving a percentage of their actual costs, they will receive a lump sum payment per discharge, which represents the average cost of capital nationwide. While receiving a payment representing average costs is acceptable if a hospital has accrued savings under the capital PPS during low capital cost years, it is unacceptable for hospitals that did not have the opportunity to accrue retained earnings during a low cost period prior to the onset of the high cost phase of the capital cycle.

all medical residents nationwide; therefore, proposed changes in graduate medical education financing, Medicare and non-Medicare, will have a greater effect on New York City than any other area of the country. In 1992, New York City hospitals alone received \$2.3 billion in Medicare and non-Medicare direct and indirect medical education payments.

Current proposals for graduate medical education (GME) reform, including President Clinton's, have several elements in common. First, they would change the current allocation process by creating a new, Federal regulatory program that applies a cap on the overall number of physicians in training, and allocate residency positions with the aim of achieving a desired primary to specialty care physician mix. Second, the financing of GME would be reformed by replacing all current GME financing with a new national pool (or pools) funded by all payers, including Medicare, that would pay for residency positions approved through the new regulatory mechanism.

GNYHA strongly supports the promotion of a physician complement geared to meeting the population's primary and preventive health care needs, but believes that this should:

1. Be performed locally by medical education consortia or similar entities according to a set of flexible goals, not regulatory quotas;
2. Be based upon a formal evaluation of the physician workforce needs of the country;
3. Undertake residency reductions only upon an assessment that adequate supplies of substitute practitioners exist;
4. Reform the system in a way that recognizes and preserves the excellence of the existing medical education infrastructure;
5. Provide adequate transition payments to institutions losing residencies to pay for replacement personnel;
6. Separate restructuring of the allocation from the financing mechanisms, keeping many features of the existing GME funding system intact and creating a new pool for negotiated rate payers only; and
7. Recognize institution-specific costs and make GME payments to the entity incurring the costs of training.

Now I will discuss these principles in more detail.

1. Reform Goals Should be Identified Through Systematic Evaluation of the Nation's Physician Workforce Needs: Current discussions on GME reform have assumed that there should be a cap on the total number of approved entry level residency positions that is tied to 110% of United States medical graduates, and also that there should be a 55%-45% mix between entering primary and specialty residents. These crucial assumptions, which would drive dramatic changes in the GME system and have a profound impact on the health care delivery system, have emerged principally from observations of physician supply in other countries. Many in the medical education community believe that while international comparisons may be helpful they are not in and of themselves adequate proxies for what is appropriate in this country. It is also widely believed that the competitive managed care environment that has increasingly taken hold in the country is creating a natural demand for primary care physicians that will improve the supply of primary care physicians. Under the President's health reform plan, the demand for primary care physicians would surely increase as coverage for primary and preventive care is included in the standard benefits package. The effects of these changes in the marketplace need to be evaluated more fully and the needs of our own population studied more carefully prior to engaging in fundamental restructuring of the GME system.

2. After National Targets Are Established, Implementation Should Be Left to Local Implementation: GNYHA believes that regions should be granted flexibility in achieving the

GME reform goals identified as a result of the systematic evaluation I have just described. Each state, and each region within large states, has a unique demographic and health care profile, economy, and medical education infrastructure that would not be well served by a Federal regulatory residency allocation system. Therefore, implementation should be left to local areas through, for example, regional medical education consortia composed of teaching hospitals (including hospitals with freestanding programs) and their affiliated medical schools. Each consortium could be charged with the responsibility of allocating residencies internally in a way that follows overall GME targets, and positions could be allocated to networks, subset medical education consortia, or freestanding programs. The effectiveness of the consortia should be judged by their results. Over time, if desired results are not achieved, a regulatory approach could be considered.

3. Residency Reductions Should Be Undertaken only if Substitute Practitioners Exist to Mitigate the Effect of Residency Losses: Nationally, GME programs have simultaneously fulfilled many missions, foremost among them physician education and services to patients. Residency training has been especially important in New York State and City, which historically have been leaders in medical education and physician training, and are home to some of the most impoverished and medically underserved populations in the nation. Residency programs in New York City continue to provide important training opportunities to new physicians who, in return and under faculty supervision, deliver needed, high quality services to patients.

It is far from clear that sufficient numbers of quality substitute practitioners who are willing and able to substitute for residents are available, and it is anticipated that in many instances the cost of residency replacement will be high. The populations of large urban areas, therefore, are at significant risk if residency reductions are made without regard to the actual availability of quality professionals who can and are willing to provide substitute services for residents. Therefore, residency reductions should be undertaken only if and when substitute practitioners of comparable quality are determined to be available.

4. GME Reform Targets Should Preserve the Excellence of the Existing Medical Education Infrastructure: GME reform should recognize the importance of preserving the medical education infrastructure. New York City is home to six medical schools, some of international renown, as well as dozens of affiliated residency programs. These programs train physicians for New York State as well as the rest of the country. The New York community's investment over the past century has ensured the production of highly qualified and trained physicians for the nation, and care should be taken that this national benefit is not lost or undermined in GME reform.

5. GME Financing: Finally, GNYHA believes that GME financing mechanisms should be developed separate and apart from the allocation process. Financing should not be the vehicle to achieve GME reform but should follow automatically from the residency allocation process. With this principle in mind, GNYHA advocates that the allocation process be relied upon to achieve reform goals, that current mechanisms for funding GME, through Medicare and private payment rates, remain intact to the extent possible, and that a new GME pool be established funded through surcharges on negotiated rate payers only, such as HMOs and other managed care plans. In this way, teaching hospitals which incur the costs of training under the new system would be guaranteed the funds necessary to maintain quality teaching programs.

CONCLUSION

I greatly appreciate this opportunity to submit testimony for the Subcommittee's use and to present GNYHA's early views of the Administration's proposal for health and GME reform. To reiterate, while we strongly support the goals of reform, particularly the provision of universal coverage, we remain concerned with the financing strategy presented to date because it appears to put New York City area health care providers at substantial risk. GNYHA looks forward to working constructively with the Subcommittee in the coming months in crafting a reform plan that improves the lives and health of all Americans, and does not disadvantage urban and inner-city communities.

FINANCING MECHANISM OF HEALTH REFORM PROPOSAL

Estimated Fiscal Impact
1996-2000
(\$ in Billions)

	<u>NYC Impact</u>	<u>Federal Impact</u>
Estimated Revenue from the Newly Insured:	\$8.0	—
Estimated Losses from Cuts in Public Programs:		
• Elimination of Medicaid DSH	(\$4.0)	N/A ¹
• Cuts in Medicare Reimbursement (Excl. Direct GME):		
- Reduce Marketbasket Update	(0.4)	(8.9)
- Reduce IME Add-On to 3%	(2.2)	(16.7)
- Reduce Capital PPS Update	(0.5)	(10.3)
- Eliminate Medicare DSH	(2.8)	(21.5)
- Reduce Hospital-Based SNF and Home Health Rates	(0.2)	(3.4)
- Establish Outpatient PPS	(1.2)	(21.8)
- Reduce Laboratory Rates	(0.1)	(2.8)
• Establish National Average Rate for Direct GME	<u>(0.6)</u>	<u>(0.0)</u>
Total Losses:	(\$12.0)	(\$85.4)²
Net Loss Due to Financing Mechanism of Health Reform Proposal:	(\$4.0)	—

¹ While projected Federal savings from the elimination of Medicaid disproportionate share funding have not been specified, total Federal Medicaid savings are estimated at \$114 billion over five years.

² Proposed Federal Medicare cuts total \$124 billion; therefore, combined Federal Medicare and Medicaid cuts total \$238 billion.



Hinsdale Hospital

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November 22, 1993

The Honorable Fortney H. "Pete" Stark
U.S. Representative, CA-13
Chairman, Ways and Means Health Subcommittee
239 Cannon
Washington, D.C. 20515

**TESTIMONY FOR WAYS AND MEANS HEALTH SUBCOMMITTEE HEARING
SCHEDULED FOR 11/23/93**

Dear Congressman Stark:

Hinsdale Hospital commends President Clinton for developing a health care reform plan that offers Americans health care security through universal access. The American Health Security Act of 1993 provides an excellent starting point for discussion and debate towards the outcome of developing a piece of legislation that will continue to provide all Americans with the best health care system in the world. We concur with the president on these major elements of the plan:

- Achieving universal access.
- Restructuring of the health care delivery system around community-based networks of health care providers.
- Instituting antitrust reforms that will allow providers to collaborate with one another to better allocate health resources.
- The creation of a standard national benefits package that emphasizes primary and preventive care.

During our analysis of the Clinton plan, we identified a major concern, that of the proposed \$124 billion in Medicare reductions. At the present time, Medicare represents 44 percent of Hinsdale Hospital's patient mix. Between 1989 and 1992, we have seen a 13.5 percent increase in the number of inpatient Medicare patients. We can only wonder why the Clinton plan calls for additional cuts in a program that will continue to grow as the "baby boomer" generation approaches retirement age.

In the OBRA 93 bill, apart from cuts in the defense budget, reductions in the Medicare budget were the greatest -- \$56 billion, representing a 6 percent reduction. It appears that legislators believe that payments to hospitals and physicians can be reduced by billions of dollars without endangering the quality of patient care. This is a false assumption.

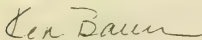
We have estimated that the Medicare reduction provisions of OBRA 93 will negatively impact Hinsdale Hospital by \$2.9 million. At this point it is difficult to calculate the impact of the proposed \$125 billion in the Clinton plan, but we estimate that it will represent an additional \$6 million, which added to the \$2.9 million from OBRA 93, totals nearly a \$9 million reduction in payment for the costs of providing care to Medicare patients. These reductions greatly hinder our ability to provide quality health care services to our patient population, and will undoubtedly mean a reduction in services.

Historically, Medicare providers have received inadequate reimbursement for services rendered to patients. At present, hospitals are paid less than 90 percent of average patient costs. During 1992, based on the actual cost of providing Medicare services and reimbursement for those services, Hinsdale Hospital lost \$8 million.

We believe that it is unconscionable for Congress to continually propose reductions in a program that already forces providers to realize a loss, and encourage the members of your committee to look at other areas that will raise revenue to support health care reform, such as an increased tobacco tax above the proposed level, and a tax on wine, beer and liquor. As a health care provider, we strongly believe that individuals who continue to partake of substances that attribute to disease should pay an additional amount to support the nation's health care program.

Thank you, Congressman Stark, for providing the opportunity for us to share our concerns. We look forward to working with members of your committee to develop a proposal that guarantees quality health care for all Americans.

Sincerely,

A handwritten signature in dark ink, appearing to read "Ken Bauer". The signature is fluid and cursive, with a long, sweeping underline.

Ken Bauer
President

TESTIMONY OF METROPOLITAN CHICAGO HEALTHCARE COUNCIL

On behalf of the Metropolitan Chicago Healthcare Council's 92 member hospitals, the Council appreciates the opportunity to present our position on the President Clinton's proposed changes to the Medicare Program. The Council agrees with much of what President Clinton has proposed for reform of our nation's health system. However, we strongly disagree with the President's call for extensive Medicare cuts.

MCHC member hospitals oppose Medicare cuts as a means of financing national health reform. It is important to have the historical perspective on this position.

Last February, MCHC took a position in support of the President's proposed "economic stimulus" plan. Although the President called for approximately \$50 billion to be taken from Medicare and Medicaid, MCHC supported the President. This position was taken with the understanding that the President was looking for "shared sacrifice" from all sectors of the economy, ultimately for the benefit of our economy and our society as a whole. MCHC also took the position that we should remain focused on the important long term goal of national health reform.

MCHC endorsed the concepts of national health reform contained in the health reform plan of the American Hospital Association. MCHC acknowledged that there is a compelling need for universal access for all Americans to an appropriate level of health care. To finance such an endeavor calls for shared efforts and shared sacrifice from all sectors of our economy. Through building on our present employment based system of coverage, simplifying the administration of health care, and integrating the delivery of health care to avoid duplication and inefficiencies, we can reach for and achieve this goal. We share these goals with President Clinton, and with many members of Congress, and we look forward to working together to achieve them.

After MCHC took these positions Congress and President Clinton agreed to cut \$56 billion from Medicare over five years as part of budget legislation. Further, an additional \$7 billion over five years was cut from Medicaid. These cuts will translate into a \$740 million reduction in Medicare Reimbursement for metropolitan Chicago area hospitals over this five year period.

Now, President Clinton is calling for unprecedented slashes of \$125 billion from Medicare and \$65 billion from Medicaid, both over six years, as part of his health reform plan. We estimate, the impact to metropolitan Chicago area hospitals to be \$2 billion, and possibly as high as \$3 billion over six years.

Chicago is home to many hospitals with significant teaching programs. The medical education cuts called for by President Clinton will have a particularly negative effect on these MCHC members.

Further, these Medicare cuts significantly impact reimbursement for capital expenditures and the numerous hospitals serving a disproportionate number of Medicare patients.

The level of cuts which the President is proposing for the hospital field is a complete abrogation of the concept of "shared sacrifice." While it is attractive to try to convince people that these cuts can be made simultaneously as health care coverage is expanded, we all know the reality that people cannot get something for nothing.

MCHC strongly supports the goals of national health reform. We believe just as strongly that financing health reform through Medicare cuts works against these goals, and sets up the American people for bitter disillusionment as this reform becomes a reality.

While the President is calling for these Medicare cuts, he is not calling for any limits to Medicare benefits. He is not calling for a reduction in the size of the population now served by Medicare by changing the eligibility criteria. In fact, the President is calling for an expansion of Medicare benefits to cover prescription drugs, financed in large part through proposed Medicare cuts.

Yet, hospitals now provide care to Medicare beneficiaries at a loss. Chicago area hospitals are currently reimbursed on average at a rate of 90¢ for every dollar of cost (not charges). In other words, on average MCHC members lose 10¢ for every dollar spent on the cost of serving Medicare beneficiaries. This figure is based on the current Medicare payment rate, before the \$56 billion cuts of OBRA 1993, and without the additional cuts proposed by President Clinton. Hospitals have been financially able to absorb this underpayment through cost shifting-- raising the charges for private paying patients to cover government's underpayment.

Through President Clinton's plan for health alliances, the pressures of competition would severely limit, or perhaps completely eliminate hospitals' ability to cost shift. Managed competition, which is also included in several leading health reform plans in Congress, can be an effective way of forcing providers to take their own steps to push their prices down. However, this goal only makes sense if the government pays to cover the cost of the health services which it purchases and eliminates the need for cost shifting.

Allow us to make one thing clear: we are not asking for "hand-outs." Medicare payments to hospitals are simply reimbursement for services provided to Medicare beneficiaries. This reimbursement must cover the cost of care provided in order for health reform to work in the way the President has presented it to the American people.

What is the result of the plan for Medicare cuts which the President has put forth? With extreme Medicare payment shortfalls (coming on the heels of \$56 million cut last spring, and \$43 million cut in OBRA 1990), hospitals will be put in an untenable situation. Hospitals will have fewer funds available for medical supplies, testing, equipment, and labor costs; at the same time as demographic trends show that the number of seniors and their demand for services will continue to grow. This situation will seriously jeopardize the Medicare program.

This is not the picture that is being presented to our nation's seniors, who are being told by the President that their benefits will be expanded to cover prescription drugs. We all remember well the debacle of the Medicare catastrophic care legislation, which was repealed after an outcry from our nation's elderly. The Medicare cuts called for in President Clinton's legislation present a much graver threat to the health security of our nation's elderly. This Congress should not, on the one hand, promise our nation's seniors expanded benefits, while at the same time cutting Medicare provider reimbursement so that this expansion is not possible.

In conclusion, we appreciate the opportunity to present the Council's views as part of this Subcommittee's record. While the topic of today's hearing is the President's proposed Medicare changes, and this issue is vitally important to health reform, the Council hopes to have the opportunity to address members of Congress about other aspects of national health reform as well. MCHC member hospitals share the President's goals of universal access, administrative simplification, and shared sacrifice, among others. We look forward to working with the Congress to develop the best plan not just to promise universal health care, but to actually achieve this goal in the years to come. Thank you.

STATEMENT OF
 ROB SCHWARTZ, PRESIDENT
 THE NATIONAL ASSOCIATION OF REHABILITATION FACILITIES
 BEFORE THE SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS
 U.S. HOUSE OF REPRESENTATIVES
 REGARDING PRESIDENT CLINTON'S HEALTH CARE REFORM PLAN
 AND THE PROPOSED MEDICARE AND MEDICAID CUTS

NOVEMBER 23, 1993

Dear Mr. Chairman:

The National Association of Rehabilitation Facilities ("NARF") appreciates your holding hearings on the subject of the Medicare and Medicaid cuts included in President Clinton's health care reform plan. NARF is concerned that the level of cuts is extremely high and would have a detrimental affect on providers' and beneficiaries' ability to provide service.

The National Association of Rehabilitation Facilities ("NARF") represents over 900 medical, vocational, and residential community-based rehabilitation facilities. These include the majority of free-standing PPS-exempt rehabilitation hospitals, rehabilitation units, and those PPS-exempt long term hospitals involved in rehabilitation.

NARF has been concerned for a number of years about the current payment methodology for Medicare PPS-exempt rehabilitation hospitals and units and those long term hospitals which serve rehabilitation patients. This methodology, known as TEFRA, for the Tax Equity and Fiscal Responsibility Act of 1992, pays PPS-exempt entities their costs, subject to a limit known as the TEFRA target ceiling limitation. To this end, the Association, at its October 1993 Board of Directors' Meeting, adopted a proposal to put forth to the Congress and the Administration on moving towards a prospective payment system for these PPS-exempt entities and to allow for interim rebasing between the date legislation is enacted and when the PPS would go into effect.

We recommend that this proposal be considered by the Subcommittee at the time it considers health care reform and as part of any changes it may consider to the Medicare system.

I. Background

For several years, providers of inpatient rehabilitation services have been divided by a fault line created by TEFRA limits on Medicare reimbursement. Hospitals and units that were in existence in the early 1980s generally have low limits, while newer hospitals and units have much higher limits, or none at all. Since Medicare is a major source of revenue for most providers of rehabilitation, this is a major issue. The extent of this division can be seen from the data on Attachments 1 and 2, which show the position of hospitals and units relative to TEFRA limits. These data are drawn from cost reports for years ending in 1990 and 1991, the most recent periods available through HCFA.

Some relief was provided for hospitals and units over limits in OBRA 90, whereby a portion of costs over limits are reimbursed starting with fiscal years beginning on and after October 1, 1991. There is general recognition that the TEFRA system, intended in 1952 to be a temporary measure, is seriously flawed for the following reasons:

1. Medicare pays widely varying amounts for similar services, producing serious inequities among competing institutions.
2. New hospitals and units can establish limits based on contemporary wage levels and otherwise achieve much higher limits than older hospitals.
3. By treating all rehabilitation discharges as having the same economic value, the TEFRA system provides a strong incentive to admit and treat short-stay, less complex cases and to avoid long-stay complex cases.
4. Because any change in services that will increase average length of stay or intensity of services will likely result in cost over a TEFRA limit, the system inhibits the development of new programs.
5. The process for administrative adjustment of limits does not provide a remedy because it is not timely (HCFA never decides cases within the period required by law) and does not recognize many legitimate costs.

II. The Proposal

This proposal has two elements: adoption of a prospective payment plan for rehabilitation based on Functional Related Groups (FRGs) and, as an interim step pending adoption of FRGs, rebasing of TEFRA limits to reflect current costs. Rebasing does not cure the principal defects of TEFRA – the absence of adjustment of payment to reflect case mix and the distortions in costs and services produced by TEFRA limits. It is intended only to mitigate the worst financial inequities of TEFRA, pending early introduction of a PPS for rehabilitation.

The actions and analyses described below are budget neutral. This point is discussed below.

A. Modification To TEFRA

1. Rebasing

A rehabilitation hospital, long term hospital or rehabilitation unit currently having TEFRA limits would be assigned its Medicare cost reporting period ending on or after September 30, 1993, as a new TEFRA base year. Limits for subsequent periods would be determined based on per-discharge Medicare operating cost in this period.

2. Hold Harmless Incentive Payments, If Any

To protect incentive payments received in the new base year, a "hold harmless" provision would be added. Medicare payment per discharge in any subsequent period would not be less than the Medicare payment per discharge in the new base year (operating cost plus incentive divided by discharges) updated to the year in question.

3. Allowance for Facilities With Very Low Limits

Some rehabilitation hospitals and units have made radical changes in operations because of TEFRA, usually dramatically reducing lengths of stay through case mix changes and other means. This was necessary because the financial drain imposed by restrictive TEFRA limits offered no alternatives. Rebased limits for this group will continue to inhibit appropriate patient admission and treatment.

To address this problem, no rehabilitation hospital or unit would, in the rebasing process outlined above, be assigned a limit that was less than 70% of the national average for its class of provider. The national average would be determined by HCFA from the most recent period for which data are available and updated to the rebasing year by appropriate TEFRA update factors. The 70% floor is proposed because any facility that is meeting the criteria for exclusion from PPS and Medicare coverage guidelines for treatment of rehabilitation patients cannot reasonably have costs much less than this amount.

4. Limits for New Facilities

Rehabilitation hospitals, long term hospitals and rehabilitation units excluded from the PPS on or after October 1, 1993, would continue to establish base years and TEFRA limits in accordance with present policy. However, Medicare operating cost per discharge in the TEFRA base year would not be recognized in calculating limits for subsequent periods to the extent to which it exceeded the estimated national average limit for its class of provider for that year by more than 10%. The estimated national average limit would be determined by taking the actual national average for the most recent period for which data are available subsequent to rebasing and updating it to the current year by TEFRA update factors.

The purpose of this limit is to restrict the potential for new providers receiving unlimited cost reimbursement while in direct competition for staff and patients with hospitals and units subject to TEFRA limits.

5. Full Market Basket Updates

The foregoing actions would inhibit potential increases in Medicare outlays for inpatient rehabilitation by eliminating the open-ended opportunity to create high TEFRA limits and the current ability of many providers to increase costs and be reimbursed 100% by the Medicare program. In recognition of these changes, rehabilitation should be exempted from any freezes or reductions in TEFRA updates and receive updates at the full market basket.

6. Budgetary Implications

The net effect of this proposal, if adopted, would be to reduce TEFRA limits for hospitals that are under their limits and raise limits for those that are over, subject to the points discussed in 2 and 3 above. Based on data for fiscal years ending in 1991 (the most recent data available from HCFA), this

action would reduce the budget baseline for inpatient hospital rehabilitation services. The Federal budget baseline assumes that all providers are paid at their limits. This is logical since under current law they have the right to have reimbursement up to such levels, if and as costs are incurred.

Attachments 1 and 2 provide data on the collective position of rehabilitation hospitals, long-term hospitals, and rehabilitation units in the most recent reporting periods available from HCFA (mostly 1991). These data account for about 90% of providers in these categories.

Using the data on these schedules and the database from which they were drawn, the Federal budgetary effect of the actions proposed (using 1991 data) is as follows:

Costs over limits allowed by rebasing:

1. Units	\$109,900,000
2. Hospitals (rehab and long term)	<u>\$ 32,500,000</u>
Total	\$142,400,000
3. Less cost sharing over limits ¹	
4. (OBRA 90)	\$ 44,400,000
5. Net increase from rebasing	\$ 98,000,000
6. Minimum Limit 70% of national average	\$ 54,000,000
7. Retention of incentive payments	<u>\$ 52,000,000</u>
8. Total cost of proposal	\$204,000,000
9. Offset from reduction of limits to cost (lines 9-8)	(\$224,600,000)
10. Net effect on Federal Budget	(\$ 20,600,000)

An allowance for administrative adjustment of limits is not included because there are no good data on this item. In any event, such adjustments are probably no more than the "net effect" amount shown above.

These calculations use data from cost reports ending approximately two years ago and current data would certainly yield different numbers. It is reasonable to assume that the relationships of these factors would be similar in more recent periods.

B. Prospective Payment For Rehabilitation

The rebasing plan outlined above will provide some temporary relief from a poor regulatory scheme. In any event, such adjustments are helpful, but do not remedy one point that is a fatal flaw of TEFRA: basing payment on the assumption that all patients in rehabilitation have the same requirements for service. Only a payment system that is based on appropriate classification of patients relative to anticipated duration and intensity of treatment will cure this defect.

In 1991, NARF entered into a contract with the Department of Rehabilitation Medicine of the University of Pennsylvania Medical Center to determine the feasibility of developing a patient classification system for inpatient rehabilitation. That research produced a classification system, titled Functional Related Groups (FRGs). The system predicts length of stay in inpatient rehabilitation based on a combination of impairment group, functional motor, and cognitive status and age. The FRG system was developed with data from 58 hospitals and 69 units that contributed to the Uniform Data System (UDS) data base. The research team, headed by Dr. Margaret Stineman, was completing the final report in 1993.

Thus, a patient classification system for inpatient rehabilitation now exists. That system may be refined and improved, but the objective of creating a classification system that reasonably measures expected duration and intensity of treatment has been attained. There are 57 FRGs. A payment system based on patient classification would adopt the format of the Medicare PPS, substituting FRGs for DRGs. A rehabilitation hospital or unit would be paid a fixed amount per discharge based on a patient's FRG classification. Other adjustments used in the DRG system, for regional wage variations and disproportionate share, would also apply. The amount to be paid for a Medicare patient treated

¹ The Omnibus Budget Reconciliation Act of 1990 provides for partial Medicare payment of cost over limits. The Medicare program now reimburses 50% of cost over the TEFRA ceiling to a maximum of 110% of such ceiling. The amount shown is that which would have been paid automatically under this provision and, therefore, is not additional cost associated with rebasing.

In a rehabilitation hospital or rehabilitation unit could be the product of the following calculation:

Standardized amount x FRG x wage index (applied to the wage portion) x
disproportionate share (if applicable).

The two new elements in this calculation are the standardized amount and the FRG. A standardized amount would presumably be the average cost for Medicare discharges in a given period.

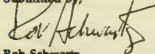
Beyond determining a standardized amount, a few other issues would need to be addressed. These include possible effects of underreporting differences between hospitals and units, transitional rules, and treatment of passthrough costs. The University of Pennsylvania is currently conducting research on the impact of co-morbidities on the FRGs and outliers. While there are some small variations for intensity of services per day, most of the differences among FRGs reflect lengths of stay.

NARF is advocating adoption of the Functional Related Groups (FRGs) as a basis for Medicare payment for inpatient rehabilitation services while continuing to encourage research to enhance the predictive capacity of the system, including specifically the effect of co-morbidities and outliers.

III. The Schedule

Because not all hospitals and units now produce data on functional status of patients, it is assumed that perhaps two years will be required to introduce such a system. Over 50% of rehabilitation hospitals and units are now reporting data to the UDS and most others use similar systems. For the latter, conversion or adaptation would not be a major problem. UDS has already modified its data collection system to compute FRGs. In light of this constraint and the time required for consideration of this proposal, rebased TEFRA limits should be effective for two cost reporting periods beginning on and after October 1, 1994. Medicare reimbursement for periods beginning on or after October 1, 1996, should be controlled by a FRG-based system.

Submitted by,



Rob Schwartz
President
/rt

Attachments

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**MEDICARE COSTS VS. TEFRA LIMITS
OF LONG TERM AND REHABILITATION HOSPITALS**

Total Hospitals Reporting	167
Under Limit	62
Over Limits	53
No Limits	52
Average Length of Stay (Under)	23.49
Average Length of Stay (Over)	25.44
Average Length of Stay (No Limit)	27.88
Average No. Medicare Days (Under)	13,137
Average No. Medicare Days (Over)	9,827
Average No. Medicare Days (No Limit)	7,406
Average No. Medicare Discharges (Under)	559
Average No. Medicare Discharges (Over)	386
Average No. Medicare Discharges (No Limit)	266
Average Cost per Discharge (Under)	\$10,436
Average Cost per Discharge (Over)	\$11,509
Average Cost per Discharge (No Limit)	\$17,552
Average TEFRA Limit (Under)	\$12,761
Average TEFRA Limit (Over)	\$9,920
Average Cost per Day (Under)	\$444
Average Cost per Day (Over)	\$452
Average Cost per Day (No Limit)	\$629
Average Medicare Cost Under Limits	\$1,300,792
Average Medicare Cost Over Limits	\$613,688
Total Cost Under Limits	\$80,649,080
Total Cost Over Limits	\$32,525,450

MEDICARE COSTS OF REHABILITATION UNITS VS. TEFRA LIMITS

Total Units Reporting	618
Under Limit	276
Over Limits	328
No Limits	14
Average Length of Stay (Total)	20.7
Average Length of Stay (Under)	19.5
Average Length of Stay (Over)	21.9
Average No. Medicare Days (Total)	3,911
Average No. Medicare Days (Under)	4,117
Average No. Medicare Days (Over)	3,738
Average No. Medicare Discharges (Total)	189
Average No. Medicare Discharges (Under)	211
Average No. Medicare Discharges (Over)	171
Average Cost per Discharge (Total)	\$10,217
Average Cost per Discharge (Under)	\$9,355
Average Cost per Discharge (Over)	\$10,942
Average TEFRA Limit (Total)	\$10,431
Average TEFRA Limit (Under)	\$11,827
Average TEFRA Limit (Over)	\$8,982
Average Cost per Day (Total)	\$490
Average Cost per Day (Under)	\$480
Average Cost per Day (Over)	\$500
Average Medicare Cost Under Limits	\$521,615
Average Medicare Cost Over Limits	\$335,066
Total Cost Under Limits	\$143,965,460
Total Cost Over Limits	\$109,901,640



Nichols Institute

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November 23, 1993

The Honorable Fortney Stark
 Chairman
 Subcommittee on Health
 House Ways and Means Committee
 1114 Longworth House Office Building
 Washington, D.C. 20515

Dear Chairman Stark:

Thank you for the opportunity to express the views of Nichols Institute regarding the proposed reductions and changes in Medicare reimbursement that are part of President Clinton's Health Security Act.

Testimony was received today by the House Ways and Means Subcommittee on Health regarding these proposed reductions and changes in Medicare reimbursement for clinical laboratory services. Please include this letter as part of the hearing record for today's hearing.

Overview of Nichols Institute

Nichols Institute is the nation's fifth largest clinical laboratory and is based in San Juan Capistrano, California. Nichols Institute was founded in 1971 as a reference laboratory and, in 1985, began to be publicly traded on the American Stock Exchange. Also in 1985, Nichols Institute began to acquire regional laboratories and now owns regional laboratory facilities in twelve states along the West Coast and throughout the Midwest and Southwest. Each of these laboratories reflects Nichols' commitment to the delivery of the highest quality laboratory services in an environment that places a priority on servicing the needs of their customers, whether they are patients, hospitals, private payor organizations, health maintenance organizations, or physicians.

Nichols Institute is not a member of either the American Clinical Laboratory Association (ACLA) or the American Association of Bioanalysts. However, we join in the clinical laboratory industry's opposition to the proposed reductions in Medicare reimbursement and support of direct billing. This support is reflected in our being a signatory on recent letters that went to Congress on these issues. Those letters are included in the materials submitted by ACLA.

Proposed Changes Threaten Lab Industry

The changes proposed by the Clinton Administration to finance health care reform are alarming and threaten the future of the clinical laboratory industry. As have many laboratories, Nichols Institute is still in the midst of a major campaign initiated within the past two years to dramatically reduce costs to be able to effectively compete. This effort to reduce costs has occurred at a time when Congress just approved reductions in Medicare reimbursement totalling \$3.3 billion and costs to comply with both the Clinical Laboratory Improvement Act Amendments of 1988 (CLIA '88) and the Occupational Safety and Health Administration's rules on blood borne pathogens have significantly increased.

Further reductions in Medicare reimbursement through reinstatement of coinsurance and utilization of competitive bidding will reduce Medicare reimbursement by another \$9.8 billion over the next five years. The additional cuts proposed would represent more than two and a half times what Medicare Part B spent on laboratory services in 1992 alone. If adopted, these cuts combined with the reductions made earlier this year, would reduce Medicare reimbursement by nearly 40 percent in one year.

Competitive Bidding: Diminishes Access and Quality

The President's Plan proposes to establish a competitive bidding process for the acquisition of clinical laboratory services. While the bill is unclear what procedures would be utilized to implement this proposal, it would appear that a "winner take all" approach would be used. In addition, the President's Plan would require ten percent reductions annually if competitive bidding didn't achieve cuts of this magnitude.

Competitive bidding raises several concerns. First, previous use of competitive bidding by the Air Force for pap smears proved disastrous. The winning laboratory performed so poorly that the program was terminated early and over 700,000 pap smears were impounded due to errors that were discovered. Second, competitive bidding creates every incentive for a clinical laboratory to "low ball" the bid in order to win the business. This has enormous implications on the quality of testing and jeopardizes health care received by patients. Thirdly, Medicare beneficiaries would experience diminished access. Losing bidders would find it difficult to stay in business, since Medicare generally comprises 25 to 30 percent of a laboratory's overall business, and patients would find access to services greatly diminished as a result. Lastly, the proposal would appear to discriminate against independent clinical laboratories by excluding hospital based laboratories and physician office laboratories.

Coinurance is a Further Reduction in Reimbursement

The proposal to reinstate coinurance is also disturbing in that reinstatement would abrogate an agreement the clinical laboratory industry reached with Congress in 1984. The basic terms of this agreement were that the clinical laboratory industry would accept reductions in reimbursement, adoption of a fee schedule and mandatory assignment in exchange for the elimination of coinurance.

The reinstatement of coinurance represents an additional reduction in reimbursement, will negatively impact beneficiaries and has no impact on utilization. Laboratories will be in the position of attempting to collect copy amounts of less than \$5 on the most frequently performed tests. The costs to collect those amounts will easily exceed \$5 after factoring in the cost to generate invoices and assign personnel to collect these sums. Past experience indicates that nearly 50 percent of the copy amounts will be written off as bad debt. Beneficiaries will be impacted by higher outlays which could reduce their access to laboratory services. Utilization is not impacted because patients have no control over a physicians decision to order a test. In the end, coinurance results in a further reduction in reimbursement of approximately 15 percent.

Direct Billing: Only Means to Curb Utilization

To truly impact utilization while ensuring the availability of quality laboratory testing, Nichols Institute would propose that the Congress adopt direct billing for all clinical laboratory services. Direct billing would require a clinical laboratory performing a test to bill a patient or a third party payer directly, rather than bill the physician who historically has marked-up these tests to a patient or third party payer. Congress had mandated direct billing under the Medicare program since 1984 and it has curbed utilization. However, its full impact has been hindered by the fact that it has not been extended to other payers.

As the Center for Health Policy Studies (CHPS) report cited in the ACLA testimony indicates, requiring direct billing for all payers would significantly cut utilization and have the effect of producing large health expenditure savings. Direct billing eliminates the incentive for a physician to order additional tests, since the physician can't profit from those tests, and reduces costs to patients by eliminating any mark-up of those tests to the patient or a third party payer.

In closing, true "reform" within the clinical laboratory should begin with direct billing. Further reductions in Medicare reimbursement will have no impact on the rising cost of Part B laboratory services since the test orderer, the physician, has no incentive to change his or her ordering pattern. Direct billing would truly change physician behavior by eliminating the potential to profit from the number or types of tests that are ordered.

Thank you for your consideration of the views of Nichols Institute.

Sincerely,

Stephen J. Brase

Stephen J. Brase
President
Regional Laboratories

Statement for the Record
Congressman Don Sundquist
November 23, 1993 Health Subcommittee Hearing
on the President's Health Care Reform Proposal:
Changes to the Medicare Program

As of January 1992, the Medicare program has based payments on a resource-based relative value scale (RBRVS) that was originally developed by researchers at Harvard University and refined and implemented by the Health Care Financing Administration as part of a congressional mandate from the Omnibus Budget Reconciliation Act of 1989. Many health plans in the private sector are now adopting this system of physician reimbursement and many more will do so under the Clinton plan.

The RBRVS contains relative values for physician work, practice expense or overhead, and malpractice for most of the services that physician provide. The physician work component is based on the Harvard University study (as a study of resources that went in to the physician work element of providing a particular service, such as time, effort, stress, level of difficulty, etc), while the practice expense and malpractice components continue to be based on the Medicare system's previous basis of physician payment, namely historical charges. However, the President's plan calls for basing practice expenses on resource costs beginning in the year 1997.

There are other studies of relative physician work values that were developed after the Harvard University study that merit serious consideration. One such study, developed by Abt Associates contains relative values for physician work for otolaryngology procedures and compares them to the physician values in the Medicare physician fee schedule or RBRVS.

The Abt study of physician work values for otolaryngology procedures is based on actual surveys of otolaryngologists who were asked to rate the work involved in providing certain procedures and from consensus panels of knowledgeable practicing physicians. The method and protocol followed were of the highest scientific standards and the values are not based on historical changes. In contrast, many of the work values for otolaryngology procedures and other services listed in the Medicare physician fee schedule were extrapolated from historical charges despite widespread acknowledgement that the historical charge data used were flawed. The Abt study is worthy of evaluation by the government and private third party payers especially in comparison to the current Medicare fee schedule work values.

The Abt study contains physician work values on some 470 primary procedures that make up the bulk of otolaryngology services as well as work values for about 350 additional procedure codes that otolaryngologists share with other specialists.

The Abt study tables of relative values for physician work for otolaryngology services are attached. The tables contain the following information for each otolaryngology service: (1) the CPT code used by physicians and insurers for billing purposes; (2) the global time period for payment policy purposes; (3) a short description of the service; (4) the Abt study work value; (5) the Medicare fee schedule (MFS) work value; (6) the percentage difference between the Abt and MFS work values; (7) the total 1991 Medicare frequency of the service; (8) 1991 Medicare data on the percentage performed by otolaryngologists; and (9) 1991 Medicare data on the total frequency of the service performed by otolaryngologists.

Abt Restudy of Otolaryngology—Head & Neck Surgery
Final Work RVUs
Secondary Codes

CPT	Global	Abt Work	MFS Work	% Diff Abt/MFS	1991 Medicare			
					Total Freq	Oto	Oto Freq	
10140	010	Incision and drainage of hematoma, seroma, or fluid collection	0.90	1.52	-40.8%	81,304	0.2%	125
10180	010	Incision and drainage, complex, postoperative wound infection	3.44	2.25	52.8%	9,012	0.7%	65
11041	000	Debridement, skin, full thickness	1.27	0.84	51.1%	124,417	0.1%	99
11042	000	Debridement, skin, and subcutaneous tissue	1.80	1.14	57.8%	181,742	0.2%	414
11043	010	Debridement, skin, subcutaneous tissue, and muscle	2.33	1.87	24.5%	57,150	0.3%	154
11044	010	Debridement, skin, subcutaneous tissue, muscle, and bone	3.39	2.34	44.7%	22,980	0.5%	120
11423	010	Excision, benign lesion, except skin tag (unless listed elsewhere)	1.25	2.17	-42.4%	30,407	1.7%	505
11424	010	Excision, benign lesion, except skin tag (unless listed elsewhere); scalp, neck, hands, feet, genitalia, lesion diameter 2.1 to 3.0 cm	1.50	2.63	-43.0%	11,016	2.3%	248
11425	010	Excision, benign lesion, except skin tag (unless listed elsewhere); scalp, neck, hands, feet, genitalia, lesion diameter 3.1 to 4.0 cm	2.00	3.82	-47.7%	7,326	3.2%	235
11444	010	Excision, other benign lesion (unless listed elsewhere); face, ears, eyelids, nose, lips, mucous membrane, lesion diameter 3.1 to 4.0 cm	2.38	3.45	-31.0%	8,804	6.2%	549
11446	010	Excision, other benign lesion (unless listed elsewhere); face, ears, eyelids, nose, lips, mucous membrane, lesion diameter over 4.0 cm	3.25	4.55	-28.6%	4,201	9.8%	411
11620	010	Excision, malignant lesion, scalp, neck, hands, feet, genitalia, lesion diameter 0.5 cm or less	1.04	1.32	-21.4%	18,091	1.3%	229
11621	010	Excision, malignant lesion, scalp, neck, hands, feet, genitalia, lesion diameter 0.6 to 1.0 cm	1.38	1.97	-29.8%	50,617	1.1%	537
11622	010	Excision, malignant lesion, scalp, neck, hands, feet, genitalia, lesion diameter 1.1 to 2.0 cm	1.64	2.35	-30.1%	58,230	1.6%	923
11623	010	Excision, malignant lesion, scalp, neck, hands, feet, genitalia, lesion diameter 2.1 to 3.0 cm	2.16	2.95	-26.7%	19,162	3.1%	559
11624	010	Excision, malignant lesion, scalp, neck, hands, feet, genitalia, lesion diameter 3.1 to 4.0 cm	3.44	3.47	-0.9%	6,526	4.3%	281
11626	010	Excision, malignant lesion, scalp, neck, hands, feet, genitalia, lesion diameter over 4.0 cm	4.60	4.31	6.8%	4,725	6.9%	325
11950	000	Subcutaneous injection of "filling" material (eg, collagen); 1 cc or less	0.53	0.00		1,006	0.8%	8
11951	000	Subcutaneous injection of "filling" material (eg, collagen); 1.1 to 5.0 cc	1.06	0.00		41	4.9%	2
11952	000	Subcutaneous injection of "filling" material (eg, collagen); 5.1 to 10.0 cc	1.59	0.00		2		0
11954	XXX	Subcutaneous injection of "filling" material (eg, collagen); over 10.0 cc	2.12	0.00		187	0.5%	1
11960	090	Insertion of tissue expander(s) for other than breast, including subsequent expansion	6.82	6.19	10.1%	1,035	2.2%	23
11970	090	Replacement of tissue expander(s) with permanent prosthesis	7.50	6.81	10.1%	424	0.5%	2
11971	090	Removal of tissue expander(s) without insertion of prosthesis	1.71	1.55	10.1%	280	1.8%	5
12001	010	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet), 2.5 cm or less	0.72	1.69	-57.5%	121,081	0.1%	111
12002	010	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet), 2.6 cm to 7.5 cm	1.01	1.85	-45.6%	100,294	0.1%	72
12004	010	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet), 7.6 cm to 12.5 cm	1.43	2.24	-36.2%	13,871	0.0%	5
12005	010	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet), 12.6 cm to 20.0 cm	2.01	2.88	-30.2%	3,388	0.1%	5
12006	010	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet), 20.1 cm to 30.0 cm	2.75	3.71	-25.9%	762	0.1%	7
12007	010	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet), over 30.0 cm	3.44	4.17	-17.5%	240		0
12011	010	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes, 2.5 cm or less	1.15	1.75	-34.3%	53,245	0.8%	424
12013	010	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes, 2.6 cm to 5.0 cm	1.53	1.99	-22.9%	32,240	0.6%	197
12014	010	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes, 5.1 cm to 7.5 cm	1.92	2.47	-22.4%	5,655	0.5%	28
12015	010	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes, 7.6 cm to 12.5 cm	2.68	3.21	-16.4%	1,893	0.7%	14
12016	010	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes, 12.6 cm to 20.0 cm	3.64	3.97	-8.3%	296	2.4%	7
12017	010	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes, 20.1 cm to 30.0 cm	4.44	4.77	-6.8%	72		0
12018	010	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes, over 30.0 cm	5.24	5.61	-6.6%	31	3.2%	1
12020	010	Treatment of superficial wound dehiscence, simple closure	1.32	2.63	-49.7%	2,714	0.7%	18
12021	010	Treatment of superficial wound dehiscence, with packing	1.32	1.83	-27.7%	2,275	0.8%	18
12031	010	Layer closure of wounds of scalp, axillae, trunk and/or extremities (including hands and feet), 2.5 cm or less	1.06	2.15	-50.8%	11,584	0.8%	95

Abi Restudy of Otolaryngology – Head & Neck Surgery
Final Work RVUs
Secondary Codes

CPT	Global		Abi Work	MFS Work	% Diff Abi/MFS	1991 Medicare		
						Total Freq	% Oto	Oto Freq
12032	010	Layer closure of wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.6 cm to 7.5 cm	132	248	-46.7%	21,534	0.4%	77
12034	010	Layer closure of wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 7.6 cm to 12.5 cm	159	294	-46.0%	5,762	0.3%	18
12035	010	Layer closure of wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 12.6 cm to 20.0 cm	212	346	-38.6%	2,101	0.5%	10
12036	010	Layer closure of wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 20.1 cm to 30.0 cm	360	409	-11.9%	620	0.2%	1
12037	010	Layer closure of wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); over 30.0 cm	487	473	2.9%	324	0.9%	3
12041	010	Layer closure of wounds of neck, hands, feet and/or external genitalia; 2.5 cm or less	088	238	-62.9%	7,839	1.1%	85
12041	010	Layer closure of wounds of neck, hands, feet and/or external genitalia; 2.6 cm to 7.5 cm	132	276	-52.0%	9,982	0.9%	89
12042	010	Layer closure of wounds of neck, hands, feet and/or external genitalia; 7.6 cm to 12.5 cm	188	316	-40.6%	1,832	0.6%	11
12044	010	Layer closure of wounds of neck, hands, feet and/or external genitalia; 12.6 cm to 20.0 cm	254	368	-31.0%	461	0.9%	4
12045	010	Layer closure of wounds of neck, hands, feet and/or external genitalia; 20.1 cm to 30.0 cm	408	431	-5.3%	105	1.9%	2
12046	010	Layer closure of wounds of neck, hands, feet and/or external genitalia; over 30.0 cm	640	471	35.9%	36	2.8%	1
12047	010	Layer closure of wounds of neck, hands, feet and/or external genitalia; 2.5 cm or less	130	248	-47.6%	19,675	3.6%	738
12052	010	Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm	182	279	-34.8%	19,834	2.8%	510
12053	010	Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 5.1 cm to 7.5 cm	221	314	-29.7%	4,220	3.1%	131
12054	010	Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 7.6 cm to 12.5 cm	260	350	-25.8%	1,582	3.2%	51
12055	010	Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 12.6 cm to 20.0 cm	384	449	-14.4%	324	8.6%	28
12056	010	Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 20.1 cm to 30.0 cm	561	532	5.4%	64	10.9%	7
12057	010	Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; over 30.0 cm	909	606	50.0%	20	5.0%	1
13120	010	Repair, complex, scalp, arms, and/or legs; 1.1 cm to 2.5 cm	250	333	-24.9%	3,739	1.5%	57
13121	010	Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm	486	439	10.7%	9,254	1.0%	97
13131	010	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm	265	383	-30.9%	14,352	3.4%	492
13132	010	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm	423	432	-2.0%	25,952	3.3%	845
13150	010	Repair, complex, eyelids, nose, ears and/or lips; 1.0 cm or less	265	385	-31.3%	3,341	10.3%	343
13151	010	Repair, complex, eyelids, nose, ears and/or lips; 1.1 cm to 2.5 cm	339	451	-24.9%	9,334	9.0%	836
13152	010	Repair, complex, eyelids, nose, ears and/or lips; 2.6 cm to 7.5 cm	529	643	-17.7%	9,085	9.6%	871
13160	090	Secondary closure of surgical wound or dehiscence, extensive or complicated	883	977	-9.6%	7,399	1.1%	83
13300	010	Repair, unusual, complicated, over 7.5 cm, any area	926	524	76.7%	6,783	3.3%	226
14020	090	Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10 sq cm or less	518	623	-16.8%	7,875	3.3%	261
14021	090	Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10.1 sq cm to 30.0 sq cm	935	959	3.7%	3,237	2.8%	84
14041	090	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10.1 sq cm to 30.0 sq cm	794	1100	-27.9%	8,282	8.7%	724
14061	090	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10.1 sq cm to 30.0 sq cm	1196	1170	2.2%	3,924	15.3%	601
14300	090	Adjacent tissue transfer or rearrangement, more than 30 sq cm, unusual or complicated, any area	1338	1102	21.4%	3,469	7.1%	246
15000	222	Excisional preparation or creation of recipient site by excision of essentially intact skin (including subcutaneous tissues), scar, or other lesion prior to repair with free skin graft	291	200	45.5%	17,866	2.0%	351
15100	090	Split graft, trunk, scalp, arms, legs, hands, and/or feet (except multiple digits), 100 sq cm or less, or each one percent of body area of infants and children (except 15059)	503	825	-39.1%	34,293	0.8%	291
15101	222	Split graft, trunk, scalp, arms, legs, hands, and/or feet (except multiple digits), each additional 100 sq cm, or each one percent of body area of infants and children, or part thereof	254	176	44.3%	14,826	0.2%	31
15121	222	Split graft, face, eyelids, mouth, neck, ears, orbita, genitalia, and/or multiple digits, each additional 100 sq cm, or each one percent of body area of infants and children, or part thereof	291	274	6.2%	574	10.1%	58
15220	090	Full thickness graft, free, including direct closure of donor site, scalp, arms, and/or legs; 20 sq cm or less	503	760	-33.9%	2,903	2.7%	78
15221	222	Full thickness graft, free, including direct closure of donor site, scalp, arms, and/or legs; each additional 20 sq cm	294	122	106.1%	502	2.0%	10
15240	090	Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; 20 sq cm or less	756	850	-11.0%	7,980	7.1%	588
15241	222	Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; each additional 20 sq cm	376	190	97.7%	645	7.3%	47

Abt Restudy of Otolaryngology—Head & Neck Surgery
Final Work RVUs
Secondary Codes

CPT	Global		Abt Work	MFS Work	% Diff Abt/MFS	Total Freq	1991 Medicare	
							Oto	Freq
15261	ZZZ	Full-thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lip, each additional 20 sq cm	4 50	2 28	97 2%	281	14 9%	42
15570	090	Formation of direct or tubed pedicle, with or without transfer, trunk	5 45	3 84	41 9%	9	11 1%	1
15572	090	Formation of direct or tubed pedicle, with or without transfer, scalp, arms, or legs	6 56	3 89	68 6%	6		0
15574	090	Formation of direct or tubed pedicle, with or without transfer, forehead, cheeks, chin, mouth, neck, axilla, genitalia, hands, or feet	10 58	3 94	168 5%	36	13 9%	5
15576	090	Formation of direct or tubed pedicle, with or without transfer, eyelids, nose, ears, lip, or intraoral	10 90	4 38	148 8%	63	6 3%	4
15600	090	Delay of flap or sectioning of flap (division and inset) at trunk	5 45	1 74	213 1%	140	7 1%	10
15610	090	Delay of flap or sectioning of flap (division and inset) at scalp, arms, or legs	6 56	2 26	190 2%	136	5 1%	7
15620	090	Delay of flap or sectioning of flap (division and inset) at forehead, cheeks, chin, neck, axilla, genitalia, hands (except 15625), or feet	8 73	2 76	216 3%	440	16 8%	74
15630	090	Delay of flap or sectioning of flap (division and inset) at eyelids, nose, ears, or lips	9 84	3 09	218 4%	804	15 8%	127
15650	090	Transfer, intermediate, of any pedicle flap (eg, abdomen to wrist, "walking" tube), any location	8 20	3 70	121 6%	116	14 7%	17
15734	090	Muscle, myocutaneous, or fasciocutaneous flap, trunk	23 38	16 92	36 2%	6 045	3 4%	206
15740	090	Flap, island pedicle	9 76	9 69	0 7%	911	7 0%	64
15750	090	Flap, neurovascular pedicle	11 69	10 87	7 6%	141	12 8%	18
15755	090	Free flap (microvascular transfer)	37 19	29 03	28 1%	735	4 4%	32
15775	000	Punch graft for hair transplant, 1 to 15 punch grafts	3 02	0 00		1		0
15776	000	Punch graft for hair transplant, more than 15 punch grafts	4 23	0 00		2		0
15780	090	Dermatoplasty, total face (eg, for acute scarring, fire wounding, myiids, general keratosis)	6 31	6 89	-8 4%	286	1 0%	3
15781	090	Dermatoplasty, segmental face	2 95	4 78	-38 2%	765	8 5%	65
15783	090	Dermatoplasty, superficial any site, (eg, tattoo removal)	1 26	4 27	-70 5%	81	6 2%	5
15786	010	Ablation, single lesion (eg, keratosis, scar)	0 84	2 03	-58 6%	16 633	0 2%	39
15787	ZZZ	Ablation, each additional four lesions of less	0 20	0 33	-38 2%	1 631	2 7%	44
15790	090	Chemical peel (chemodermatolysis), total face	6 31	6 59	-4 3%	542	1 3%	7
15819	090	Canthoplasty	5 61	9 09	-38 3%	29	13 8%	4
15820	090	Blepharoplasty, lower eyelid	4 21	4 91	-14 3%	288	8 0%	23
15821	090	Blepharoplasty, lower eyelid, with extensive hermetic lid pad	5 00	5 50	-9 0%	347	4 9%	17
15822	090	Blepharoplasty, upper eyelid	3 36	4 38	-23 2%	6 897	3 1%	216
15823	090	Blepharoplasty, upper eyelid, with excessive skin weighing down lid	4 21	6 81	-38 2%	14 299	2 8%	401
15824	XXX	Rhytidectomy, forehead	8 41	0 00		565	6 7%	38
15825	XXX	Rhytidectomy, neck with platysmal tightening (platysmal flap, "p-lap")	9 26	0 00		5	20 0%	1
15826	XXX	Rhytidectomy, glabellar frown lines	4 21	0 00		9	11 1%	1
15828	XXX	Rhytidectomy, cheek, chin, and neck	10 58	0 00		44	20 5%	9
15829	XXX	Rhytidectomy, superficial musculopneumonic system (SMAS) flap	10 72	0 00		18	16 7%	3
15840	090	Graft for facial nerve palsy, free tissue graft (including obtaining fascis)	7 99	12 56	-36 4%	136	22 8%	31
15841	090	Graft for facial nerve palsy, free muscle graft (including obtaining graft)	23 12	22 06	4 8%	15	20 0%	3
15842	090	Graft for facial nerve palsy, free muscle graft by microsurgical technique	38 46	26 86	4 3%	28	3 0%	1
15845	090	Graft for facial nerve palsy, regional muscle transfer	12 80	12 09	5 9%	189	19 6%	37
15850	XXX	Removal of sutures under anesthesia (other than local), same surgeon	0 95	0 00		1 807	0 2%	4
15851	XXX	Removal of sutures under anesthesia (other than local), other surgeon	0 95	0 88	8 2%	4 070	0 9%	38
15876	XXX	Suction assisted liposuction, head and neck	4 21	0 00		10	20 0%	2
17010	010	Destruction by any method, including laser, with or without surgical curettage, all benign facial lesions or premalignant lesions in any location, or benign lesions other than	0 80	1 03	-22 8%	14 652	0 3%	45

Abt Restudy of Otolaryngology—Head & Neck Surgery
Final Work RVUs
Secondary Codes

CPT	Global	Abt Work	MFS Work	% Dif Abt/MFS	Total Freq	1991 Medicare % Dif Oto	Oto Freq
17101	222 Destruction by any method, including laser, of benign skin lesions other than cutaneous vascular proliferative lesions on any area other than the face, including local anesthetic	0.05	0.11	-57.2%	425,761	0.1%	463
17102	222 Destruction by any method, including laser, of benign skin lesions other than cutaneous vascular proliferative lesions on any area other than the face, including local anesthetic	0.05	0.11	-57.2%	792,924	0.1%	618
17104	010 Destruction by any method, including laser, of benign skin lesions other than cutaneous vascular proliferative lesions on any area other than the face, including local anesthetic	0.88	2.06	-57.2%	86,409	0.2%	196
17104	010 Destruction by any method, including laser, of benign skin lesions other than cutaneous vascular proliferative lesions on any area other than the face, including local anesthetic	0.33	0.78	-57.2%	6,012	0.3%	17
17105	010 Destruction by any method, including laser, of benign skin lesions other than cutaneous vascular proliferative lesions on any area other than the face, including local anesthetic	1.99	4.65	-57.2%	524	4.8%	25
17106	090 Destruction of cutaneous vascular proliferative lesions (eg, laser technique), less than 10 sq cm	3.97	9.28	-57.2%	230	1.1%	4
17107	090 Destruction of cutaneous vascular proliferative lesions (eg, laser technique), 10.0 - 50.0 sq cm	5.74	13.42	-57.2%	132	3.0%	4
17108	090 Destruction of cutaneous vascular proliferative lesions (eg, laser technique), over 50.0 sq cm	4.39	1.89	132.2%	3,647	0.7%	26
20000	010 Incision of soft tissue abscess (eg, secondary to osteomyelitis), superficial	5.85	3.09	89.3%	2,244	1.4%	32
20000	010 Incision of soft tissue abscess (eg, secondary to osteomyelitis), deep or complicated	0.85	0.78	8.5%	2,242	0.4%	10
20501	090 Injection of sinus tract, diagnostic (angiogram)	1.69	1.84	-8.0%	3,180	0.4%	13
20520	010 Removal of foreign body in muscle or tendon sheath, simple	5.13	3.31	55.0%	1,713	0.3%	5
20525	010 Removal of foreign body in muscle or tendon sheath, deep or complicated	1.74	1.73	0.6%	17,746	0.3%	54
20670	010 Removal of implant, superficial (eg, buried wire, pin or rod) (separate procedure)	3.35	3.33	0.6%	34,779	0.2%	84
20680	090 Removal of implant, deep (eg, buried wire, pin, screw, metal band, rod or plate)	3.63	3.61	0.6%	2,435	0.4%	10
20690	222 Application of a uniplane (pins or wires in one plane), unilateral, external fixation system	3.04	5.16	-41.1%	1,067	11.7%	125
20900	090 Bone graft, any donor area, minor or small (eg, dowel or button)	6.45	6.91	-6.6%	4,818	0.2%	10
20902	090 Bone graft, any donor area, major or large	6.40	5.16	24.0%	147	8.2%	12
20910	090 Cartilage graft, costochondral	2.86	4.98	-42.6%	68	8.8%	6
20920	090 Fascia lata graft, by stripper	4.02	6.19	-35.1%	205	4.4%	9
20922	090 Fascia lata graft, by incision and area exposure, complex or sheet	4.23	5.16	-18.0%	604	17.1%	103
20926	090 Tissue graft, other (eg, paratenon, fat, dermis)	56.55	0.00		41	4.9%	2
20955	090 Bone graft with microvascular anastomosis, iliac	56.55	0.00		185	1.1%	2
20962	090 Bone graft with microvascular anastomosis, other bone graft (specify)	56.55	0.00		21	23.8%	5
20970	090 Free osteocutaneous flap with microvascular anastomosis, iliac crest	4.02	4.13	-2.6%	70	2.9%	2
21100	090 Application of halo type appliance for maxillofacial fixation, includes removal (separate procedure)	2.99	4.86	-38.5%	7		0
21120	090 Genuoplasty, augmentation (autograft, allograft, prosthetic material)	4.98	7.64	-34.8%	10		0
21121	090 Genuoplasty, sliding osteotomy, single piece	9.12	8.41	8.5%	4		0
21122	090 Genuoplasty, sliding osteotomy, two or more osteotomies (eg, wedge excision or bone wedge reversal for asymmetrical chin)	11.93	11.00	8.5%			
21123	090 Genuoplasty, sliding augmentation with interpositional bone grafts (includes obtaining autografts)	5.98	6.37	-6.1%	22	9.1%	2
21125	090 Augmentation, mandibular body or angle, prosthetic material	11.60	10.69	8.5%	11		0
21127	090 Augmentation, mandibular body or angle, with bone graft, only or interpositional (includes obtaining autograft)	6.03	0.00		2		0
21137	090 Reduction forehead contouring only	8.04	0.00		8		0
21138	090 Reduction forehead contouring and application of prosthetic material or bone graft (includes obtaining autograft)	10.05	0.00		29		0
21139	090 Reduction forehead contouring and setback of anterior frontal sinus wall	16.09	17.34	-7.2%	16		1
21144	090 Reconstruction midface, LeFort I, infusion, single piece (eg, Long Face Syndrome)	20.11	19.38	3.8%	41		0
21145	090 Reconstruction midface, LeFort I, single piece, any direction, requiring bone grafts (includes obtaining autografts)	28.15	20.06	40.3%	2	14.3%	1
21146	090 Reconstruction midface, LeFort I, three or more pieces, any direction, requiring bone grafts (includes obtaining autografts) (eg, ungated unilateral alveolar cleft)	32.17	20.80	54.7%	29		0
21147	090 Reconstruction midface, LeFort I, three or more pieces, any direction, requiring bone grafts (includes obtaining autografts)	45.49	0.00		1		0
21151	090 Reconstruction midface, LeFort II, any direction, requiring bone grafts (includes obtaining autografts)	60.32	0.00				
21154	090 Reconstruction midface, LeFort II (extraoral), any type, requiring bone grafts (includes obtaining autografts) without LeFort I						

Abt Restudy of Otolaryngology—Head & Neck Surgery
Final Work RVUS
Secondary Codes

CPT	Global	Abt Work	MFS Work	% Diff AB/MFS	Total Freq	1991 Medicare % Oto	Oto Freq
21155	090	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts), with LeFort I	63.48	0.00			
21160	090	Reconstruction midface, LeFort II (extra and intracranial) with forehead advancement (eg, micro bloc), requiring bone grafts (includes obtaining autografts), without LeFort I	63.74	0.00			
21169	090	Reconstruction midface, LeFort II (extra and intracranial) with forehead advancement (eg, micro bloc), requiring bone grafts (includes obtaining autografts), with LeFort I	76.33	0.00			0
21170	090	Reconstruction superior-lateral orbital rim and lower forehead advancement or elevation, with or without grafts (includes obtaining autografts)	32.17	0.00			15 6.7%
21172	090	Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or elevation (eg, flapoccephaly, temporocephaly, trichostaphyly), with or without gra	60.32	0.00			8 12.5%
21182	090	Reconstruction of orbital walls, rims, forehead, nasomaxillo complex following intra- and extracranial excision of benign tumor of canal bone (eg, fibrous dysplasia), with n	40.22	0.00			11 18.2%
21183	090	Reconstruction of orbital walls, rims, forehead, nasomaxillo complex following intra- and extracranial excision of benign tumor of canal bone (eg, fibrous dysplasia), with n	48.26	0.00			1
21184	090	Reconstruction midface, osteotomies (other than LeFort types) and bone grafts (includes obtaining autografts)	52.28	0.00			2
21188	090	Reconstruction midface, osteotomies (other than LeFort types) and bone grafts (includes obtaining autografts)	30.16	0.00			0
21193	090	Reconstruction of mandibular ramus, horizontal, vertical, "C", or "L" osteotomy, without bone graft	18.04	16.63	8.5%		3
21194	090	Reconstruction of mandibular ramus, horizontal, vertical, "C", or "L" osteotomy, with bone graft (includes obtaining graft)	20.90	19.27	8.5%		6
21195	090	Reconstruction of mandibular ramus, sagittal split, without internal rigid fixation	18.08	16.67	8.5%		5
21206	090	Osteotomy, maxilla, segmental (eg, Wassmund or Schuchard)	19.94	18.38	8.5%		5
21208	090	Osteoplasty, facial bones, augmentation (autograft, allograft, or prosthetic implant)	20.11	13.69	46.9%		5
21209	090	Osteoplasty, facial bones, reduction	6.03	9.80	-38.4%		6
21210	090	Graft, bone, nasal, maxillary or malar areas (includes obtaining graft)	4.02	6.43	-37.5%		32
21215	090	Graft, bone, mandible (includes obtaining graft)	8.04	9.80	-17.9%		447
21216	090	Graft, bone, mandible (includes obtaining graft)	11.18	10.31	8.5%		375
21230	090	Graft, no cartilage, autogenous, to face, chin, nose or ear (includes obtaining graft)	11.18	10.31	8.5%		84
21240	090	Arthroplasty, temporomandibular joint, with or without autograft (includes obtaining graft)	9.97	13.42	-25.7%		411
21242	090	Arthroplasty, temporomandibular joint, with allograft	7.98	12.39	-35.6%		67
21243	090	Arthroplasty, temporomandibular joint, with prosthetic joint replacement	14.95	19.44	-23.1%		43
21244	090	Reconstruction of mandible, external, with transnasal bone plate (eg, mandibular sagittal bone plate)	15.95	11.35	40.5%		192
21246	090	Reconstruction of mandible or maxilla, subperiosteal implant, complete	12.95	11.94	8.5%		23
21247	090	Reconstruction of mandible or maxilla, subperiosteal implant, partial	29.91	21.67	38.0%		17
21248	090	Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder), partial	13.91	11.35	-20.7%		268
21249	090	Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder), complete	13.91	17.54	-20.7%		105
21260	090	Periorbital osteotomies for orbital hypertelorism, with bone grafts, extracranial approach	72.31	15.82	357.1%		2
21261	090	Periorbital osteotomies for orbital hypertelorism, with bone grafts, combined intra- and extracranial approach	63.74	30.15	111.4%		
21263	090	Periorbital osteotomies for orbital hypertelorism, with bone grafts, with forehead advancement	78.34	27.21	187.9%		
21267	090	Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts, extracranial approach	28.15	18.10	55.5%		23
21270	090	Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts, extracranial approach	5.29	12.39	-57.3%		16
21280	090	Maxillary augmentation, prosthetic material	8.04	5.78	39.1%		147
21282	090	Maxillary augmentation, prosthetic material	4.76	3.34	42.5%		720
21295	090	Lateral canthotomy (separate procedure)	10.58	1.47	619.7%		5
21310	090	Reduction of masseter muscle and bone (eg, for treatment of benign masseteric hypertrophy), extraoral approach	0.53	0.60	-11.8%		1,907
21316	090	Closed treatment of nasal bone fracture, with or without manipulation	5.29	4.86	8.8%		5.29
21330	090	Open treatment of nasal bone fracture, with or without stabilization	25.07	10.31	143.2%		16
21340	090	Pericardial treatment of nasomaxillo complex fracture, with spinal wire or headcap fixation, including repair of cartilaginous ligaments and/or the nasomaxillo apparatus	21.48	18.88	13.8%		42
21344	090	Open treatment of complicated (eg, comminuted or involving posterior wall) frontal sinus fracture, via coronal or multiple approaches	7.46	7.81	-4.5%		19.0%

Abt Restudy of Otolaryngology—Head & Neck Surgery
Final Work RVUs
Secondary Codes

CPT	Global		Abt Work	MFS Work	% Diff Abt/MFS	1991 Medicare		
						Total Freq	% Total	Chg Freq
21347	090	Open treatment of nasomaxillary complex fracture (LeFort II type), requiring multiple open approaches	21.16	12.15	74.2%	61	24.6%	15
21348	090	Open treatment of nasomaxillary complex fracture (LeFort II type), with bone grafting (includes obtaining graft)	27.51	12.75	115.7%			
21355	010	Percutaneous treatment of fracture of malar area, including zygomatic arch and malar tripod, with manipulation	1.90	3.61	-47.2%	43	23.3%	10
21356	010	Open treatment of depressed zygomatic arch fracture (eg, Gates approach)	3.17	3.97	-20.1%			
21366	090	Open treatment of complicated leg, comminuted or involving cranial nerve foramina) fracture(s) of malar area, including zygomatic arch and malar tripod, with bone grafting	15.92	17.01	-6.4%			
21366	090	Open treatment of orbital floor "blowout" fracture, periorbital approach	6.08	8.77	-30.6%	93	23.7%	22
21390	090	Open treatment of orbital floor "blowout" fracture, periorbital approach, with alloplastic or other implant	11.21	9.71	15.5%	273	24.9%	68
21395	090	Open treatment of orbital floor "blowout" fracture, periorbital approach with bone graft (includes obtaining graft)	11.21	12.14	-7.6%	61	11.5%	7
21400	090	Closed treatment of fracture of orbit, except "blowout", without manipulation	0.95	1.34	-28.9%	79	6.3%	5
21401	090	Closed treatment of fracture of orbit, except "blowout", with manipulation	1.22	3.12	-61.0%	21	14.3%	3
21406	090	Open treatment of fracture of orbit, except "blowout", without implant	6.08	6.71	-9.3%	67	11.9%	8
21408	090	Open treatment of fracture of orbit, except "blowout", with bone grafting (includes obtaining graft)	12.16	9.29	30.8%			
21421	090	Closed treatment of palatal or maxillary fracture (LeFort I type), with interdental wire fixation or fixation of denture or splint	5.29	4.91	7.7%	106	11.3%	12
21422	090	Open treatment of palatal or maxillary fracture (LeFort I type), with interdental wire fixation or fixation of denture or splint	6.82	7.97	-14.4%	107	15.9%	17
21423	090	Open treatment of palatal or maxillary fracture (LeFort I type), complicated (comminuted or involving cranial nerve foramina), multiple approaches	9.57	9.96	-3.9%			
21432	090	Open treatment of maxillary fracture (LeFort II type), with wiring and/or internal fixation	9.57	8.25	16.1%	6	16.7%	1
21436	090	Open treatment of maxillary fracture (LeFort II type), complicated multiple surgical approaches, internal fixation, with bone grafting (includes obtaining graft)	33.60	26.85	25.1%			
21440	090	Closed treatment of mandibular or maxillary alveolar ridge fracture (separate procedure)	1.99	2.58	-22.9%	92	6.5%	6
21445	090	Open treatment of mandibular or maxillary alveolar ridge fracture (separate procedure)	2.84	5.16	-45.0%	41	14.6%	6
21450	090	Closed treatment of mandibular fracture, without manipulation	1.64	2.85	-42.5%	146	8.2%	12
21452	090	Percutaneous treatment of mandibular fracture, with external fixation	8.52	1.89	350.6%	16	18.8%	3
21453	090	Closed treatment of mandibular fracture, with interdental fixation	5.29	3.40	55.6%	23	4.3%	1
21454	090	Open treatment of mandibular fracture with external fixation	10.32	6.19	66.6%	111	11.7%	13
21461	090	Open treatment of mandibular fracture, without interdental fixation	5.29	7.74	-31.7%	183	19.7%	36
21462	090	Open treatment of mandibular fracture, with interdental fixation	9.60	9.37	2.5%	259	13.1%	34
21465	090	Open treatment of mandibular fracture, with maxillary fracture	15.34	11.40	34.5%	24		0
21470	090	Open treatment of complicated mandibular fracture by multiple surgical approaches including internal fixation, interdental fixation, and/or wiring of dentures or splints	24.29	14.54	67.1%	646	14.1%	91
21480	090	Closed treatment of temporomandibular dislocation, initial or subsequent	1.06	0.63	67.9%	940	7.3%	69
21485	090	Closed treatment of temporomandibular dislocation, complicated (eg, recurrent requiring intraoral fixation or splinting, initial or subsequent)	6.40	3.82	67.6%	383	13.8%	53
21490	090	Open treatment of temporomandibular dislocation	14.18	11.35	24.9%	13	7.7%	1
21555	090	Excision tumor, soft tissue of neck or thorax, subcutaneous	3.70	4.19	-11.6%	2,062	15.3%	315
21630	090	Radical resection of adenoma, for tumor	12.70	15.95	-20.4%	35		0
21632	090	Radical resection of adenoma, for tumor	23.86	17.02	40.2%	70	5.7%	4
30460	090	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening, tip only	11.03	9.72	13.5%			
30462	090	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening, tip only	17.85	19.44	-8.2%			
30580	090	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening, tip, septum, alaromas	3.83	6.65	-42.5%	458	15.5%	71
30600	090	Repair lipula, oromaxillary (combine with 31030 if anastomosis is included)	5.19	6.02	-13.9%	140	14.3%	20
31071	090	Simultaneous frontal, maxillary	4.44	4.90	-9.3%			
31285	090	Sinusotomy frontal, unilateral	1.06	3.87	-72.7%			
31500	000	Intubation, endotracheal, emergency procedure	2.33	2.39	-2.6%	208	341	0.3%
								535

Abt Restudy of Otolaryngology – Head & Neck Surgery
Final Work RVUs
Secondary Codes

CPT	Global		Abt Work	MFS Work	% Dif Abt/MFS	Total Freq	1991 Medicare	
							%	Oto Freq
31605 000	Tracheostomy, emergency procedure, cricothyroid membrane		688	3 67	87 4%	491	13 6%	67
31605 001	Tracheostomy, emergency procedure, cricothyroid membrane		952			491	13 6%	67
31631 000	Bronchoscopy, with tracheal dilation and placement of tracheal stent		661	4 48	47 6%	416	23 8%	99
31635 000	Bronchoscopy, with removal of foreign body		831	3 77	120 3%	922	16 2%	149
31640 000	Bronchoscopy, with excision of tumor		603	5 06	19 2%	287	19 9%	57
31641 000	Bronchoscopy, with destruction of tumor or relief of stenosis by any method other than excision (eg, laser)		608	5 16	17 9%	2 609	12 4%	324
31645 000	Bronchoscopy, with therapeutic aspiration of tracheobronchial tree, subglottic		384	3 24	18 4%	24 152	0 8%	183
31646 000	Bronchoscopy, with therapeutic aspiration of tracheobronchial tree, subglottic		362	2 79	29 9%	3 983	1 8%	73
31730 000	Transcatheter (percutaneous) introduction of needle wire dilator/stent or inflatable tube for oxygen therapy		259	2 92	-11 2%			
31760 090	Tracheoplasty, intrathoracic		21 77	21 40	1 7%	5		0
31766 090	Cervical reconstruction		28 35	29 52	-3 9%	5		0
31770 090	Bronchoplasty, graft repair		20 79	21 67	-4 1%	13		0
31805 090	Suture of external tracheal wound or injury, intrathoracic		14 29	12 90	10 8%	8	12 5%	
38300 010	Drainage of lymph node abscess or lymphadenitis, simple		159	1 52	4 5%	388	11 1%	43
38305 090	Drainage of lymph node abscess or lymphadenitis, extensive		318	4 35	-27 0%	301	19 3%	58
38500 010	Biopsy or excision of lymph node(s), superficial (separate procedure)		318	2 90	9 5%	11 560	4 8%	557
38520 090	Biopsy or excision of lymph node(s), deep (cervical node(s)) with excision saline fat pad		635	4 97	27 8%	2 698	7 5%	202
38550 090	Excision of cystic hygroma, axillary or cervical, without deep neurovascular dissection, simple		7 94	6 58	20 7%	234	4 3%	10
38555 090	Excision of cystic hygroma, axillary or cervical, without deep neurovascular dissection, complex		15 91	13 37	19 0%	141	10 6%	15
40500 090	Vermilionectomy (lip shave), with mucosal advancement		524	4 18	25 3%	1 793	22 0%	395
40520 090	Excision of lip, V - excision with primary direct linear closure		450	4 65	-3 3%	2 453	21 4%	524
40650 090	Repair lip, full thickness, vermilion only		116	3 58	-67 5%	146	8 9%	13
40652 090	Repair lip, full thickness, up to half vertical height		233	4 18	-44 3%	132	11 4%	15
40654 090	Repair lip, full thickness, over one half vertical height, or complex		479	5 26	-9 0%	284	12 9%	38
40700 090	Plastic repair of cleft lip/nasal deformity, primary, partial or complete, unilateral		12 59	12 33	2 1%	89	4 5%	4
40701 090	Plastic repair of cleft lip/nasal deformity, primary bilateral, one stage procedure		18 94	15 47	22 4%	1		0
40800 010	Drainage of abscess, cyst, hemangioma, vestibule of mouth, simple		1 07	1 14	-6 1%	757	14 4%	109
40801 010	Drainage of abscess, cyst, hemangioma, vestibule of mouth, complicated		1 36	2 54	-46 3%	316	8 9%	28
40804 010	Removal of embedded foreign body, vestibule of mouth, simple		136	1 22	11 8%	138	22 5%	31
40805 010	Removal of embedded foreign body, vestibule of mouth, complicated		444	2 71	63 9%	41	22 0%	9
40806 000	Incision of labial frenum (frenotomy)		0 63	0 31	104 8%	42	2 4%	1
40812 010	Excision of lesion of mucosa and submucosa, vestibule of mouth, with simple repair		243	2 32	4 9%	5 223	15 7%	822
40814 090	Excision of lesion of mucosa and submucosa, vestibule of mouth, with complex repair		352	3 35	5 0%	1 410	17 0%	240
40818 090	Excision of mucosa of vestibule of mouth as donor graft		127	2 32	-45 1%	142	21 8%	31
40819 090	Excision of frenum, labial or buccal (frenulectomy, frenulotomy)		0 85	2 32	-63 4%	204	11 3%	23
40830 010	Closure of laceration, vestibule of mouth, over 2.5 cm or less		1 69	1 75	-3 3%	167	4 8%	8
40831 010	Closure of laceration, vestibule of mouth, over 2.5 cm or complex		354	2 47	43 5%	198	9 6%	19
40840 XXX	Vestibuloplasty, anterior		5 11	0 00		122	11 5%	14
40842 XXX	Vestibuloplasty, posterior, unilateral		5 11	0 00		16	12 5%	2
40843 XXX	Vestibuloplasty, posterior, bilateral		5 11	0 00		25		0

Abt Restudy of Otolaryngology—Head & Neck Surgery
Final Work RVUs
Secondary Codes

CPT	Global		Abt Work	MFS Work	% Diff Abt/MFS	Total Freq	1991 Medicare	
							Oto	Freq
40844	XXX	Vestibulectomy, entire arch	5 11	0 00	—	45	67%	3
40845	XXX	Vestibulectomy, complex (including ridge extension, muscle repositioning)	5 11	0 00	—	123	81%	10
41006	090	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth, sublingual, deep, supramylohyoid	1 70	3 10	-45 1%	73	19 2%	14
41007	090	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth, submental space	1 70	2 96	-42 5%	27	22 2%	6
41008	090	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth, submandibular space	1 87	3 24	-42 2%	142	19 0%	27
41009	090	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth, masseteric space	2 04	3 43	-40 4%	61	24 6%	15
41010	010	Incision of lingual frenum (frenotomy)	0 63	2 22	-48 0%	59	11 9%	7
41011	090	Extralabial incision and drainage of abscess, cyst, or hematoma of floor of mouth, sublingual	6 05	3 81	58 6%	43	11 6%	5
41016	090	Extralabial incision and drainage of abscess, cyst, or hematoma of floor of mouth, submental	6 05	3 81	58 6%	52	19 2%	10
41017	090	Extralabial incision and drainage of abscess, cyst, or hematoma of floor of mouth, submandibular	6 05	3 81	58 6%	118	16 9%	20
41018	090	Extralabial incision and drainage of abscess, cyst, or hematoma of floor of mouth, masseteric space	7 00	4 86	44 1%	30	23 3%	7
41115	010	Excision of lingual frenum (frenectomy)	0 85	1 73	-51 1%	34	11 8%	4
41250	010	Repair of laceration 2.5 cm or less, floor of mouth and/or anterior two-thirds of tongue	2 76	1 90	45 1%	198	24 2%	48
41251	010	Repair of laceration 2.5 cm or less, posterior one-third of tongue	3 28	2 27	44 8%	31	12 9%	4
41510	090	Stump of tongue to lip for microglossia (Douglas type procedure)	3 01	3 40	-11 5%	5	20 0%	1
41520	090	Frenoplasty (surgical revision of frenum, eg, with Z-plasty)	3 01	2 69	11 9%	59	15 3%	9
41800	010	Drainage of abscess, cyst, hematoma from dental/alveolar structures	1 65	1 14	44 8%	473	7 2%	34
41805	010	Removal of embedded foreign body from dental/alveolar structures, soft tissues	1 77	1 22	44 8%	102	6 9%	7
41806	010	Removal of embedded foreign body from dental/alveolar structures, bone	3 92	2 71	44 8%	193	4 7%	9
41823	XXX	Excision of osseous tuberosities, dental/alveolar structures	3 01	0 00	—	340	1 8%	6
41825	010	Excision of lesion or tumor (except listed above), dental/alveolar structures, without repair	1 16	1 29	-9 7%	806	13 5%	109
41826	010	Excision of lesion or tumor (except listed above), dental/alveolar structures, with simple repair	2 11	2 32	-9 3%	1 187	7 6%	90
41827	090	Excision of lesion or tumor (except listed above), dental/alveolar structures, with complex repair	3 02	3 35	-9 9%	361	22 7%	82
42000	010	Drainage of abscess of palate, uvula	0 53	1 21	-56 3%	129	19 4%	25
42106	010	Excision, lesion of palate, uvula, with simple primary closure	1 59	2 70	-41 2%	1 285	23 3%	300
42210	090	Palatoplasty for cleft palate, with closure of alveolar ridge, with bone graft to alveolar ridge (includes obtaining graft)	14 07	10 26	37 2%	9	11 1%	1
42235	090	Repair of anterior palate, including vomer flip	8 57	7 68	11 6%	45	6 7%	3
42260	090	Repair of nasolabial fistula	3 97	4 28	-7 3%	33	24 2%	8
42325	090	Fistulization of sublingual salivary cyst (mucocele)	3 44	2 72	26 4%	45	15 6%	7
42509	090	Parotid duct diversion, bilateral (Wike type procedure), with excision of both submandibular glands	20 12	11 35	77 3%	14	14 3%	2
42510	090	Parotid duct diversion, bilateral (Wike type procedure), with ligation of both submandibular Wharton's ducts	14 41	7 90	82 4%	452	5 1%	23
42550	090	Injection procedure for sialadenitis	0 98	1 28	-23 5%	3	—	0
42835	090	Adenoidectomy, secondary, under age 12	2 65	2 27	16 5%	402	15 2%	61
42970	090	Control of nasopharyngeal hemorrhage, primary or secondary (eg, postadenoidectomy), simple, with posterior nasal packs, with or without anterior packs and/or cauterization	5 14	4 89	5 1%	256	14 8%	38
43000	090	Etiopathology, cervical approach, without removal of tongue body	5 29	6 60	-22 2%	172	5 2%	9
43217	000	Etiopathology, rigid or flexible fiberoptic (specify, for removal of polypoid lesions)	4 28	2 87	49 3%	1 388	6 8%	95
43219	000	Etiopathology, rigid or flexible fiberoptic (specify, for insertion of plastic tube or stent)	4 23	2 87	47 5%	1 169	0 1%	15
43226	000	Etiopathology, rigid or flexible fiberoptic (specify, for insertion of wire to guide dilation)	1 80	1 94	-7 3%	1 384	0 6%	8
43227	000	Etiopathology, rigid or flexible fiberoptic (specify, for control of hemorrhage (eg, electrocauterization, laser photocoagulation)	3 44	3 69	-6 8%	812	2 1%	17
43228	000	Etiopathology, rigid or flexible fiberoptic (specify, for ablation of tumor or mucosal lesion (eg, electrocauterization, laser photocoagulation)	3 60	3 86	-6 8%	—	—	—

Abt Restudy of Otolaryngology—Head & Neck Surgery
Final Work RVUs
Secondary Codes

CPT	Global		Abt Work	MFS Work	% Diff ABUMFS	1991 Medicare		
						Total Freq	% Oto	Oto Freq
43300	090	Esophagoplasty, plastic repair or reconstruction; cervical approach, without repair of tracheopharyngeal fistula	12.97	8.94	45.0%	130	24.6%	32
43410	090	Suture of esophageal wound or injury, cervical approach	10.58	9.85	7.4%	97	11.3%	11
43420	090	Closure of esophageal wound or fistula, cervical approach	11.64	10.44	11.5%	400	11.8%	47
60000	010	Closure of esophagotomy or fistula, cervical approach	2.38	1.75	36.0%	185	5.4%	10
60020	090	Incision and drainage of thyroglossal cyst, infected	10.65	10.10	5.5%	4,626	18.6%	859
60220	090	Total thyroid lobectomy, unilateral	13.33	11.94	11.6%	1,318	19.9%	262
60240	090	Thyroidectomy, total or complete	16.56	16.04	3.2%	1,761	18.1%	318
60245	090	Thyroidectomy, subtotal or partial	10.93	12.32	-11.3%	3,058	16.0%	488
60246	090	Thyroidectomy, subtotal or partial, with removal of substernal thyroid gland, cervical approach	15.55	14.51	7.2%	514	22.0%	113
60260	090	Thyroidectomy, secondary	16.08	14.84	8.4%	338	8.9%	30
60270	090	Thyroidectomy, including substernal thyroid gland, sternal split or transsternocervical approach	24.55	16.84	45.8%	176	12.5%	22
60500	090	Parathyroidectomy or exploration of parathyroid(s)	17.40	15.78	10.3%	5,367	5.5%	295
60502	090	Parathyroidectomy or exploration of parathyroid(s), re-exploration	19.57	19.72	-0.7%	163	6.7%	11
60505	090	Parathyroidectomy or exploration of parathyroid(s), with mediastinal exploration, sternal split or transsternocervical approach	27.88	20.42	36.5%	180	11.1%	20
61460	090	Cranioctomy, suboccipital, for section of one or more cranial nerves	29.76	27.41	8.6%	533	18.6%	99
61520	090	Craniotomy for excision of brain tumor, infratentorial or posterior fossa, cerebellar/pons angle tumor	3.28	3.17	3.5%	714	1.8%	13
64830	22Z	Microdissection and/or microrepair of nerve (list separately in addition to code for nerve repair)	12.64	17.14	-26.2%			
64885	090	Nerve graft (includes obtaining graft), head or neck, up to 4 cm in length	15.50	20.44	-24.2%			
64886	090	Nerve graft (includes obtaining graft), head or neck, more than 4 cm in length	0.50	1.33	-62.4%	5,182	0.5%	24
67700	010	Blepharotomy, damage of abcesses, eyelid	0.83	0.99	-16.6%	914	1.6%	15
67710	010	Stripping of tarorrhaphy	1.00	1.20	-16.6%	1,436	0.2%	3
67715	010	Cantotomy (separate procedure)	0.75	1.52	-50.7%	9,481	0.5%	51
67810	000	Biopsy of eyelid	1.25	2.04	-38.8%	29,080	0.4%	109
67840	010	Excision of lesion of eyelid (except chalazion) without closure or with simple direct closure	0.50	1.38	-63.8%	604	3.0%	18
67875	000	Temporary closure of eyelids by suture (eg, Frost suture)	10.00	4.65	115.0%	5	20.0%	1
67900	090	Repair of brow ptosis (superciliary, mid-forehead or coronal approach)	7.50	6.11	22.7%	22,698	0.6%	144
67904	090	Repair of blepharoptosis; tarsal/levator resection or advancement, external approach	3.75	5.35	-29.9%	418	1.4%	6
67909	090	Reduction of overcorrection of ptosis	5.00	5.26	-5.0%	5,284	0.9%	47
67916	090	Repair of ectropion, blepharoplasty, excision tarsal wedge	5.00	5.99	-16.6%	10,806	0.8%	84
67917	090	Repair of ectropion, blepharoplasty, extensive (eg, Kuhnt, Symplewski or tarsal strip operations)	2.50	3.40	-26.5%	7,494	0.2%	14
67921	090	Repair of entropion, suture	5.00	5.84	-14.4%	6,146	0.3%	20
67923	090	Repair of entropion, tarsal wedge	4.82	3.55	-31.5%	7,094	1.0%	71
67930	010	Suture of recent wound, eyelid, involving lid margin, tarsus, and/or palpebral conjunctiva; direct closure, partial thickness	6.25	5.54	10.8%	6,775	1.2%	82
67950	090	Cantoplasty (reconstruction of canthus)	8.18	9.80	-16.6%	5,511	0.6%	31
67961	090	Excision and repair of eyelid, involving lid margin, tarsus, conjunctiva, canthus, or full thickness, may include preparation for skin graft or pedicle flap with adjacent tissue flap	10.00	6.55	52.6%	723	0.6%	4
67966	090	Excision and repair of eyelid, involving lid margin, tarsus, conjunctiva, canthus, or full thickness, may include preparation for skin graft or pedicle flap with adjacent tissue flap	14.99	12.90	16.2%	576	1.9%	11
67971	090	Reconstruction of eyelid, full thickness by transfer of tarsalconjunctival flap from opposing eyelid, up to two-thirds of eyelid, one stage or first stage	14.99	12.87	16.5%	187	2.1%	4
67973	090	Reconstruction of eyelid, full thickness by transfer of tarsalconjunctival flap from opposing eyelid, total eyelid, lower, one stage or first stage	3.75	9.12	-58.9%	503	0.6%	3
67974	090	Reconstruction of eyelid, full thickness by transfer of tarsalconjunctival flap from opposing eyelid, upper, one stage or first stage						
67975	090	Reconstruction of eyelid, full thickness by transfer of tarsalconjunctival flap from opposing eyelid, second stage						

Abi Restudy of Otolaryngology—Head & Neck Surgery
Final Work RVUs
Secondary Codes

CPT	Global	Abi Work	MFS Work	% Diff Abi/MFS	Total Freq	1991 Medicare %	Oto Freq
69090	XXX	0.26	0.00		81	3.7%	3
69120	090	7.25	4.04	79.4%	474	24.5%	116
69710	XXX	7.46	0.00		5	20.0%	1
92508	XXX	0.26	0.26	1.7%	1,391	10.8%	150
95004	XXX	0.08	0.00				
95010	XXX	0.11	0.15	-29.5%			
95015	XXX	0.11	0.15	-29.5%			
95024	XXX	0.16	0.00				
95028	XXX	0.16	0.00				
95075	XXX	0.79	0.97	-18.2%	466	0.2%	1

HEALTH CARE REFORM: ISSUES RELATING TO MANAGED CARE

WEDNESDAY, FEBRUARY 2, 1994

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.

The subcommittee met, pursuant to call, at 10:05 a.m., in room 1100, Longworth House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
FRIDAY, JANUARY 21, 1994

PRESS RELEASE #24
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES A HEARING
ON
HEALTH CARE REFORM:
ISSUES RELATING TO MANAGED CARE

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a hearing on issues relating to managed care, as discussed in the President's health care reform proposals. This hearing will be held on Wednesday, February 2, 1994, at 10:00 a.m., in the main Committee hearing room, 1100 Longworth House Office Building.

In announcing the hearing, Chairman Stark said, "Managed care arrangements, in a variety of forms, have become an increasingly popular framework for providing health insurance coverage. The Administration's health care reform plan, among others, envisions an acceleration of this trend. This hearing is intended to explore several issues, including the evidence regarding the success of managed care as a cost containment tool and as a means of delivering health care to vulnerable populations."

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

BACKGROUND:

Managed care arrangements have become increasingly common in recent years. The General Accounting Office (GAO) has reported that enrollment in managed care plans grew from about 10 million people in 1980 to over 80 million people by 1992.

While the term "managed care" is often associated with tightly controlled health maintenance organizations (HMOs), virtually all the enrollment growth reported by GAO has been in less restrictive arrangements, such as preferred provider organizations (PPOs) and point-of-service (POS) network plans.

Enrollment growth is encouraged by many organizations based on a belief that managed care plans are less costly. The Congressional Budget Office has reported that staff and group model HMOs generate a one-time savings of 10 to 15 percent, primarily due to a lower rate of hospital admissions. Evidence with respect to the success of the other more popular types of managed care arrangements to control costs is limited.

The use of "gatekeepers," limited choice of physicians, and other mechanisms for limiting use of health care services generates questions regarding consumer satisfaction and quality of services provided through managed care arrangements. In addition, the changes managed care arrangements require with respect to how individuals access health care services and the limited experience of managed care plans in underserved communities raises questions regarding the appropriateness of managed care for these populations.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Persons submitting written statements for the printed record of the hearing should submit at least six (6) copies of their statements by the close of business on the last day of the hearings, to Janice Mays, Chief Counsel and Staff Director, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, room 1114 Longworth House Office Building, before the final hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record, or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

★ ★ ★ ★ ★

Chairman STARK. Good morning. The Subcommittee on Health is continuing its series of hearings, and we will focus today on the role of managed care, the trends for which are indelible and undeniable.

Each year, more Americans are enrolling in managed-care plans. The General Accounting Office has reported that since 1980 the number of people enrolled in some form of managed care has increased from 10 million to 80 million. In addition, more and more States are turning to managed care as a means of controlling Medicaid spending. Many health care reform proposals, including the administration's, envision or encourage an acceleration of this trend.

The expansion of managed care raises a number of issues. First, does it save money? Second, do the restrictions that managed-care plans place on the use of health services in an effort to save money serve the patients well? Third, if they don't put restrictions on to save money, what other possible restrictions have they ever suggested that improve the delivery of health care? Fourth, how well do managed care plans work for low-income populations, the elderly, the fragile and those who are chronically ill?

CBO has consistently reported that the only evidence of savings from managed care are one-time savings associated with lower rates of hospital admissions in those tightly-run staff and group model HMOs. Again, according to CBO, there is little evidence that managed care reduces growth—and I underline growth—in health spending. Moreover, virtually all of the growth in enrollment in managed-care plans has been in those looser arrangements generally referred to as Preferred Provider Organizations and point-of-service plans.

Today we have with us representatives of the GAO, who will report on their study of the extent to which the shift to managed care is saving money for employer health plans.

With respect to the issue of consumer satisfaction, a study published in the Journal of the American Medical Association last August concluded that patients rated all aspects of care by individual physician practitioners better than HMO patients, particularly with respect to waits for appointments and telephone access.

My own district reflects a mixed view. A majority, literally more than half of my constituents, are enrolled in the Kaiser Permanente health plan, and most seem very satisfied with the care they receive. They often choose to stay in Kaiser once they become eligible for Medicare, and Kaiser performs the service with fewer resources than the rest of the systems in our district.

On the other hand, Kaiser has selectively cherrypicked and held down its risks through selective enrollment over the 50 years of its existence.

I still do receive a steady stream of mail with another point of view. Many letters are from Medicare beneficiaries who have enrolled in Medicare risk contracts with HMOs or Medicare select supplemental plans, generally without a full understanding that their coverage is restricted to a limited set of providers.

I am making available today copies of a letter I received from my area about Aetna enrolling a nursing home patient with dementia in a Medicare risk contract. The doctor that Aetna assigned to this

patient refused to make nursing home visits. This kind of a life-threatening, shameful marketing practice has to be stopped.

These stories and concerns are not unique to California and raise bipartisan concerns. Congressman Clay Shaw of Florida wrote to me last December suggesting a hearing on the issues of managed care from the consumer perspective. He was motivated by the complaints about HMOs he received from Medicare beneficiaries in his district.

Today's record I ask will include a reprint of a series of articles from the Florida Sun Sentinel which discuss problems that Medicare beneficiaries have faced with HMOs in Florida.

[The information follows:]

Sun-Sentinel

Gene Cryer
Vice President
Editor

November 11, 1993

The U.S. government insists all is well with Florida HMO plans for the elderly.

Many of our readers don't agree.

Hundreds wrote, at our invitation, to share their views on Medicare health maintenance organizations, which federal officials tout as the best way to deliver low-cost, high-quality health care.

Reader complaints led us through a maze of regulatory agencies where we obtained thousands of pages of medical-quality documents through Freedom of Information Act requests.

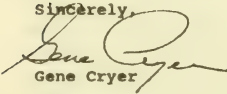
The result is "The HMO Maze: How Medicare Fails the Elderly," a five-part series by Investigations Editor Fred Schulte and Staff Writer Larry Keller, published Nov. 7-11, 1993.

The series uncovered allegations that Medicare HMOs delayed or denied vital medical care to save money. It also exposed thousands of complaints of enrollment abuses, unpaid bills, bad doctors -- and a bonus system that pays physicians more if they provide less care.

The findings should serve as a warning to Medicare officials seeking to expand the HMO program, which now spends \$1.3 billion a year to care for 300,000 senior citizens in Florida.

We'd like to share the findings with you.

Sincerely,



Gene Cryer

GC/jc

Seniors divided over HMO plans

By FRED SCHULTE
and LARRY KELLER
Staff Writers

Medicare HMO member Berte Young, of Hallandale, thinks she has found the way to stay well.

"If the government would incorporate HMOs into a health care plan on a universal basis, it would be a tremendous step forward for the nation," said Young, "70 plus," a ballroom dancing teacher.

By contrast, Irving Berger of Boca Raton thinks the Medicare HMO industry has veered far off course.

"What started out as a panacea for all seniors... wound up as a competitive football," said Berger, 81. "Instead of one valid, solid HMO, seniors are bombarded by a multiplicity of plans. It is now a monster mash."

Medicare enrollment in South Florida HMOs tops 300,000 — a little more than 20 percent of the over-65 market — and is expected to grow rapidly.

But seniors such as Young and Berger are deeply divided over the wisdom of trading standard Medicare benefits for an HMO. So are most of 353 other *Sun-Sentinel* readers who wrote to the newspaper in recent months to give their views on the health plans.

Many letters reflected distrust, even hostility, toward South Florida HMOs. Others writers were delighted with their care and rated their HMO plans as better than private doctors.

In all, 48 percent were negative, 39 percent were satisfied. The rest voiced no opinion.

While the readers' sample is unscientific, it tends to debunk HMO industry claims — bandied about in forums ranging from television advertising to congressional hearings — that 90 percent of HMO patients are satisfied with their care.

Many *Sun-Sentinel* readers ex-

pressed grave doubts, often based on personal experiences, about the quality of HMO medicine. Some attacked the Medicare HMO system, which pays doctors a fixed fee for each member, fearful that it encourages HMO doctors to limit needed medical care.

Service delays, or failure to get referrals to medical specialists, were reported by almost half the readers who disliked Medicare HMOs. Nearly one-third of the negative letters blamed a Medicare HMO for contributing to the death or injury of a loved one.

On the plus side, satisfied HMO customers reported no trouble getting service, from routine checkups to complex surgery.

Happy HMO members often cited out-of-pocket savings as a major selling point. South Florida Medicare HMOs charge no premiums because they receive about \$500 per month from the government for each patient.

"We are almost completely dependent upon our Social Security income, and with savings interest at such a low ebb at the present time we find ourselves living below the poverty level," wrote Marie and Lawrence Lyon, who live in Plantation.

"Had it not been for HMO, we would be either completely broke at the present time, or living on our children. God forbid," Marie Lyon said.

Other happy HMO members said many of the people telling horror stories failed to follow rules limiting care to physicians and hospitals affiliated with their HMO.

"Most people who are complaining are people who like not having to pay, but do not want any rules and who also want to tell the doctors what they want done," wrote Shirley Bailey of Fort Lauderdale. "Private doctors do this as it means more money for them."

Reader views

Sun-Sentinel readers either love or hate Medicare HMOs, judging from 355 letters. Overall, 39% of writers were satisfied; 48% were not; the rest stated no opinion.

PRO

Satisfied HMO members had been enrolled seven years on average, mostly in the same HMO. Many thought the HMO program should be opened to people of all ages.

"For us it has been a wonderful wellness program which could work for our whole country."

— **Thelma and Michael Gerrard, Pompano Beach**

SOURCE: Letters from *Sun-Sentinel* readers, May-August 1993



CON

30% of those unhappy blamed an HMO for causing a death or serious injury, usually because they thought the HMO failed to diagnose an ailment or delayed treating it.

"Seems like if you're in good health the HMOs are OK, but as soon as you have something serious happen, they can't find the money to help you." — **Arlene Cools, Hollywood**

Elderly consumers find HMOs can be a gamble

■ First in a series.

By FRED SCHULTE
and LARRY KELLER
Staff Writers

Morris Cohen is in pain, not for himself, but his beloved wife, Sarah. He lost her last July to cancer — amid medical errors by Florida's largest HMO for the elderly.

"Since she passed away, I can hardly read or concentrate," said the Margate resident. "It's been miserable."

Cohen knew his wife would die. But he is angry at the Humana Gold Plus Plan, which he blames for trying to save money by limiting care in the final stages of her life. Humana disputes his claims.

Many others harbor ill will toward health maintenance organizations paid by the federal government to treat the elderly, a *Sun-Sentinel* investigation found.

Thousands of South Floridians have lodged complaints against Medicare HMOs in recent years. And at least 140 people have blamed a loved one's death, injury or prolonged suffering on HMO cost-cutting practices, the newspaper found.

The study drew on thousands of pages of government complaint files and computer data, court records and more than 350 letters from the newspaper's readers.

It is the first independent effort to track the experiences of elderly patients who have shuffled through South Florida Medicare HMOs, a \$1.3 billion-a-year medical system federal officials tout as the best way to deliver low-cost health care to seniors.

HMOs are a critical part of the Clinton administration's plans to contain health-care costs, and government officials hope to boost Medicare HMO enrollment rapidly.

"HMOs are on the verge of exploding," said John Black, an official with the Florida Department of Insurance.

By no means are all HMO members upset. Some who wrote to the newspaper in recent months view the plans as a godsend, often because they shield them from soaring medical costs.

"I am a widow on a very limited budget. I could in no way afford to be without the HMO," said longtime member Doris Hoskins of Coral Springs.

Yet government records reveal that the HMO plans can be a risky bet for the elderly because they restrict access to some medical care, or may stall or refuse to pay medical bills.

Among the findings:

■ More than 10,800 patients or their families have complained to state and federal officials in recent years. Most of the complaints have concerned non-payment of bills, a pattern that appears to be getting worse.

■ Some South Florida HMOs are twice as likely as others to provide access to physicians and hospital services. Federal officials said the variations needed study to ensure HMOs do not ration services.

■ Seven South Florida HMOs are plagued by high disenrollment rates — in a few, twice as many people leave as join. The trend suggests many HMO members are dissatisfied with their care and that HMOs are far from a panacea for the elderly.

"I think we have some fairly serious quality problems with our medical system," said Doug Cook, who heads Florida's Agency for Health Care Administration.

■ Morris Cohen tries to keep busy. He leaves his small apartment early most days, because the place feels lonely without his wife of 46 years. Most mornings find him at the corner bagel shop, where the full breakfast special goes for \$1.49.

Cohen, 74, who gave up driving three years ago because of a foot problem, takes two buses several days a week to the VA clinic in Fort Lauderdale, where he does volunteer work.

And he spends a lot of time feeling guilty that he didn't do everything he could to save Sarah. "I was stupid. I should have taken her out of that HMO," he said.

Cohen followed the lead of more than 300,000 other South Florida seniors and joined an HMO. He had doubts, because he had heard that HMO patients had trouble getting appointments to see doctors. But he thought the HMO was the most he could

afford.

By joining an HMO, seniors pay no premiums. They get all medical care, prescription drugs, eyeglasses and hearing aids. The government pays the HMO about \$500 a month per patient, and the HMO must provide all necessary medical care.

Standard Medicare, by contrast, pays only 80 percent of health-care bills. An insurance policy to cover gaps in Medicare coverage would have cost Cohen \$160 every month.

Cohen said the HMO system worked fairly well — until his wife got very sick and required steady care.

"I had to fight for everything," Cohen said. "They wouldn't send her off for tests. All that time she was feeling sick."

Cohen said he watched helplessly as his wife's condition worsened. Once she was terminally ill, he said, the HMO tricked him into disenrolling her.

Cohen alleges Humana doctors and center administrators told him to quit the HMO and return to standard Medicare, which would pay for an experimental drug to treat his wife's spreading cancer.

Only after Cohen disenrolled from the HMO did he find out Medicare would not cover the cost of the drug, he said in a complaint filed with Humana in January 1992.

"We cannot find any evidence to substantiate this member's allegations regarding this matter," responded Humana official Phyllis Tannebaum. She said Humana offered to transfer Cohen to another HMO center, but he refused.

Sarah Cohen died of ovarian cancer on July 23, 1992.

But Cohen feels he won a victory of sorts on Oct. 4. After more than a year of deliberation, a group of Tampa doctors paid by Medicare to investigate medical care complaints found several shortcomings in the care Sarah Cohen received from Humana.

"I know I can't bring her back," Cohen said of his wife. "I just want Humana to admit that they did the wrong thing."

Humana's Tannebaum, however, said the panel mostly cited minor documentation errors.

■ Florida HMOs deny they cut health care costs at the expense of patients. They point out that HMOs are required by law to set up formal quality-assurance programs to guard against rationing of medical care.

But aggressive HMO cost-re-

Staff graphics/BONNIE LALKY/SEIBERT

SOURCE LINE

If you would like to leave your comments about this series, or if you have more story tips, please call the *Sun-Sentinel* Source Line after 9:30 a.m. at 523-5463 in Broward and 930-5463 in Palm Beach and Dade counties, and enter category 8211. The call is free.



Each day during this series, we will feature a pair of comments from Broward and Palm Beach county residents who have had personal experiences — good and bad — with HMOs. To hear today's remarks, please call the *Sun-Sentinel* Source Line at 523-5463 in Broward and 930-5463 in Palm Beach and Dade counties, and enter category 8210. The call is free.

duction tactics allegedly have taken a toll in human suffering, according to patient histories compiled by the *Sun-Sentinel* from six government agencies and the newspaper's readers.

Among the 140 cases of alleged denial or delay of medical services were complaints that HMO doctors refused to send patients to specialists, or failed to perform tests to diagnose illness.

In some cases, HMO complaints have been supported by court judgments, government quality audits or state medical-licensing investigations. But the majority of readers did not lodge grievances with government agencies. Some said they thought nobody would listen.

Some readers also said their HMO doctors had advised them to quit the HMO and return to Medicare if they wanted treatments ranging from cataract surgery to hip replacements.

"These cases absolutely should be looked into," said Cook, Florida's chief health care regulator. "We need to either rebuke [HMOs] or, if necessary, look at their licenses."

The *Sun-Sentinel* confirmed that since 1987, more than 10,800 complaints against South Florida Medicare HMOs have been registered with government regulators. The figure is extremely conservative because many HMO complaint records were not available.

Federal officials provided computer data showing 6,700

Continued...

1 of 2

complaints alleging enrollment abuses or quality problems. About 10 percent were quality of care problems. ■

The Medicare HMOs of South Florida are a diverse group. Three, including the largest, Louisville-based Humana Health Plans, are traded on the New York Stock Exchange.

The other publicly traded firms are Ramsay HMO Inc. and Physicians Corporation of America, or PCA.

Humana shot ahead of its competitors by purchasing troubled International Medical Centers in late 1987. The HMO had collapsed amid accusations of Medicare fraud and poor-quality medicine.

Ramsay, which opened in the early 1970s as a clinic serving Miami's Cuban exile community, also has grown and prospered. The Coral Gables-based company paid chief executive Luis Lamela more than \$11 million in compensation last year.

Other major plans include Health Options, owned by Blue Cross of Florida Inc.; Av-Med, a not-for-profit company; and CareFlorida, whose chairman is a former Dade County school board president.

The HMOs compete fiercely. Most seek to carve out turf in a frenzy of television advertising in which each portrays itself as having the best doctors.

In fact, the HMOs have major differences in access to medical services for Medicare members — variations that could be a signal for prospective members.

The HMO industry makes no apologies for cost cutting. HMO executives often say that as much as one-third of medical care is not necessary.

"The worst thing you can do is leave a person in a hospital longer than necessary. More care is not necessarily better," said Steve de Montmolin, vice president and general counsel at Av-Med HMO. ■

Government assertions of quality aside, America's seniors are not buying the Medicare HMO concept, U.S. Health Care Financing Administration data reveal.

The HMO program is adrift. In South Florida, it is being tapped largely by for-profit companies that raid each other's patients. CareFlorida, for example, derived 75 percent of its premium revenues in 1992 from the Medicare program. Miami is the nation's most lucrative market for Medicare HMOs.

Still, membership remains about one of five eligible people in South Florida, and more than half who drop out are going back on standard Medicare, apparently frustrated with HMO services.

Industry officials acknowledge that at least one in five people who leave HMOs do so because they are unhappy, or don't understand how HMOs work. Medicare members can disenroll at will, although the process takes one month to become effective.

"People don't understand what they are buying," said CAC Ramsay executive Lamela. "People don't return one out of five cars. This [HMO] concept is so new."

Some HMOs lose members faster than they can sign them up. During 1992, Av-Med enrolled 4,000 Medicare members and lost 9,800, according to U.S. government data.

Av-Med officials blamed the dropouts on a decision to charge members a \$20 monthly premium at a time when all other Medicare HMOs were free. Av-Med has rescinded the premium.

Nationwide, the growth of Medicare HMOs has sputtered. In 1990, about 1.3 million people had joined. Earlier this year, enrollment stood at about 1.5 million.

Joe Berding, Humana's chief executive in South Florida, said the key to spurring the growth of HMOs for the elderly is to persuade more doctors to join HMO networks.

"People don't join now because they like their current doctors and they can afford to stay with them," Berding said. "HMOs are a good deal for them financially."

Even Morris Cohen, sour as he is about Medicare HMOs, is reluctantly shopping for an HMO. His Medicare supplement now costs him more than \$100 a month for minimal coverage.

"Every month I'm taking more money out of the bank," said Cohen. "I'm going to have to get back on an HMO plan."

AT A GLANCE

Senior citizens have a choice for Medicare coverage:

■ **HMO:** Medicare HMOs charge no premiums in South Florida, although some do in other areas. Members get all medical care, prescription drugs, eyeglasses and hearing aids. The government pays the HMO about \$500 a month per patient, and the HMO must provide all necessary medical care. HMOs have restrictions, such as which doctors and hospitals can be used and the HMOs control access to specialists.

■ **MEDICARE:** Medicare pays about 80 percent of health-care bills. Patients must pay rest out of pocket, or can purchase an insurance policy to cover gaps in Medicare coverage.

HMOs ranked

Florida Medicare HMO plans ranked by size and tax dollars received during 1992.

	Medicare members*	Tax payment in millions of dollars
Humana Medical Plans**	211,288	\$884.4
CAC Ramsay	24,943	126.0
CareFlorida	19,182	83.9
Health Options	18,322	78.9
Av-Med	14,797	84.0
Florida Health Care Plan	9,266	26.3
PCA Health Plans	5,191	11.8
HIP Network	2,342	6.8
Family Health Plan	238	.5
Total	305,569	\$1.3 billion

* Enrollment for Medicare only. Working people are also members of HMOs.

** Includes Tampa and St. Petersburg.

SOURCE: U.S. Health Care Financing Administration computer data.

HMO scrimped on care, patient says

When Benjamin Bernstein went to his Humana HMO doctor in West Palm Beach with excruciating stomach pains, Dr. Morton Simon gave him some pain medicine and sent him home.

The pain continued, and four days later Bernstein was rushed to a hospital with a ruptured colon. The Singer Island man was in surgery for seven hours. After that he was placed in intensive care for 10 days to two weeks, said his son, Fred.

Bernstein, 79, survived, but he blames Humana for scrimping on care.

"I'm [now] wearing a colostomy bag," said Bernstein, who has since moved to Hallandale. "I can't indulge in any activities except walking. I walk with a cane."

Bernstein's lawyers contend in a lawsuit that Humana's treatment of his symptoms rather than the cause of his discomfort caused his condition to worsen and resulted in permanent injury.

Humana would not comment because the suit is pending.

SOURCE: Civil lawsuit

Family says doctor was unavailable

When Thomas Williams went to a Humana Medicare HMO center in Hialeah with chest pains, no doctor was on duty.

But the clinic staff telephoned Dr. Rafael Zornosa. For the next 45 minutes, Williams, a retired truck driver who had just turned 68, answered questions posed by Zornosa's staff, purportedly passed along by the doctor.

Zornosa prescribed nitroglycerin and some cardiac and stomach medicine.

Later that day, Williams, a Humana patient, had a heart attack and lapsed into a coma. He died two months later.

Zornosa's actions led to a lawsuit by Williams' widow last year and a six-figure settlement in January. The terms of the settlement were not disclosed.

Attorneys for Luila Mae Williams argued that Humana should have known that Zornosa was seeing too many patients, was unavailable to his patients when needed, and didn't provide adequate "on call" coverage at the center.

Zornosa practices at Hialeah Med Plus, where he treats patients from Humana and Family Health Plan.

SOURCE: Civil lawsuit

Man: 'Cost-effective' means losing testicles

Howard Silver has kept prostate cancer in check thanks to a new — and expensive — drug called Lupron. A urologist at the Cleveland Clinic Florida recommended in January that Silver keep taking the drug, which cost his Medicare HMO \$350 each month. But Silver said a CAC Ramsay doctor demanded a more "cost effective" solution — surgery to cut off Silver's testicles.

Stunned, Silver fought back. The Coral Springs resident complained to the state Agency for Health Care Administration. CAC Ramsay kept up the costly injections after the state agency intervened.

"A lot of people don't fight. I did,"

said Silver, who has since quit the HMO and returned to standard Medicare.

"These HMOs are fine for the average person who is not sick. The minute they get ill, [HMOs] look for ways to cut corners."

CAC Ramsay president Luis Lamela said it was possible Silver's doctor thought he would need the surgery eventually anyway. "It's not an economic thing at all," he said.

Three other patients have complained to the Sun-Sentinel that Medicare HMOs refused to pay for the costly prostate drug, in two cases pressuring them to undergo removal of their testicles.

SOURCE: Sun-Sentinel reader.

Patient: Hasty discharge hurt quality of life

Arthur Kelly says Health Options' haste in discharging him from a hospital diminished his life forever.

When Kelly, 72, of Davie, complained of severe back pain, he was hospitalized. Doctors diagnosed an inflammation of his heart and treated it. But after a month in the hospital, Kelly was discharged, even though his back pain persisted and its source remained undiagnosed.

Kelly said he got word he was being released from Pembroke Pines Hospital when a hospital employee told him that Health Options "paid 'x' amount of days, and that the days were up and that I would have to pay it myself if I stayed."

Kelly's wife of 53 years, Betty, phoned her husband's doctor, who told her he might be able to get Arthur Kelly another couple of days in the hospital. He did, and Kelly was then treated on an outpatient basis.

After Kelly returned home, a vertebrae collapsed from a bone disease called osteomyelitis, leaving him

paralyzed from the chest down.

Subsequent surgery, physical therapy and braces have enabled Kelly to progress from a wheelchair to a walker and a cane. Now, the retired warehouse general manager can walk unassisted — but only for about half a block.

It is a big adjustment for Kelly, who when he was healthy used his handyman skills to make home repairs and do yard work. Now he can't even help his wife with the grocery shopping or vacuuming.

"I was able to do anything . . . whether it be painting the house or wallpapering or plumbing or mechanics on a car, and now I'm not capable of doing anything," Kelly said under oath in a deposition last December. "Television is [now] my best friend."

The suit is pending.

A spokesman for Blue Cross — which has the Health Options plan — said it is company policy to not comment on pending litigation.

SOURCE: Civil lawsuit

System a blow to human dignity, son says

Juliette Verville, 90, broke her hip and fractured her right shoulder in a fall in July at the board-and-care home where she was living in Fort Lauderdale.

She lay in pain overnight while the home's staff tried to persuade her Medicare HMO — PCA Health Plans of Florida — to agree to pay for an X-ray for her, according to a complaint filed by her son.

The evening after the fall, PCA agreed to admit the 75-pound woman to Imperial Point Hospital. She was discharged after one day. Verville, unable to speak because of a previous stroke, landed back in the boarding home, which has no staff to care for injured patients. Her son, Robert, appealed to PCA to transfer his mother to a nursing home. The HMO initially refused, saying his mother must stay in the hospital three days in order to qualify for nursing home care payment.

PCA's chief medical officer, Dr. Glen Johnson, said the HMO has no three-day proviso on nursing home care.

After Robert Verville persisted, the

HMO relented and transferred his mother to a nursing home.

Robert Verville went to the home. "I found a once-proud woman reduced by the system to a crying, cast-aside, humiliated and helpless person as she lay in her own excrement, unable to reach a call button for assistance," he wrote.

Johnson disputes Verville's account of his mother's case. Juliette Verville was released from the hospital by her treating physician, and not on orders of PCA, he said.

When employees at her board-and-care home told PCA that Verville needed to recuperate in a skilled nursing center, PCA agreed to transfer her to such a place with which it contracts. But Verville's son took her to another center that was not affiliated with PCA, he said. Later, he allowed her to be moved to the PCA-affiliated center.

Said Robert Verville: "Shame on the health care system for allowing human dignity to suffer so, while encouraging profiteering."

SOURCE: Florida Department of Insurance.

Son: Tests might have saved mother

Robert Adamson thinks his mother might be alive today if CareFlorida had provided more than bare-bones medical coverage. Regina Adamson had been a CareFlorida member for three years when a cancerous growth burst through her navel early last year.

She then disenrolled from CareFlorida and was signed to Humana's Medicare HMO plan. In April 1992, a Humana doctor operated on her for colon cancer. Less than three weeks later, she enrolled again with CareFlorida. In June of last year, she died at 77.

While with CareFlorida, Regina Adamson was not given a pap smear, a mammogram or other tests that might have detected her cancer sooner, her son contends. She had regular appointments with a CareFlorida doctor to pick up blood pressure pills, but not much else, according to Robert Adamson, who lives in Hollywood.

In a letter to the Department of Insurance, CareFlorida also described Regina Adamson's care as routine. She "was seen on a monthly basis for her immediate medical problems," such as high blood pressure, until her disenrollment on Dec. 31, 1991, wrote Susan Cardoso, quality management specialist.

By then, Regina Adamson was terminally ill and had less than six months to live.

CareFlorida president Larry Kries said he had no information about the Adamson case.

The insurance department referred the complaint to the state Agency for Health Care Administration, whose findings are confidential.

SOURCE: Florida Department of Insurance

Family says cancer was detected too late

When an X-ray showed Marty Miles had a spot on his lung, his doctors at the Humana Gold Plus Plan HMO failed to detect the cause.

At the time, the Lighthouse Point man, a former smoker, was complaining of shortness of breath and weight loss.

But two years and several more abnormal X-rays later, Humana doctors still hadn't figured out that Miles had lung cancer. When a biopsy and other tests were finally done on Miles, his cancer was too widespread to treat or remove, the family contends.

After Miles died in 1991, three weeks before his 80th birthday, his widow sued Humana and three doctors for negligence.

Miles' lawyers are taking aim at the Humana plans' system that allows doctors to share in profits and creates financial incentives to limit care to patients.

Humana executives said they could not comment on pending lawsuits.

SOURCE: Civil lawsuit

Reader views

Many *Sun-Sentinel* readers cited out-of-pocket savings as a reason for joining Medicare HMOs, whether they were happy with the quality of the medical care or not.

PRO

58% of happy HMO members cited cost savings, as did 23% of HMO patients who were dissatisfied

"I have been with an HMO for six years. I have found them to care. If it wasn't for HMO, I would have lost my house, car and money. God bless them!"
— Josephine Passalacqua, Boynton Beach.

Source: Letters from *Sun-Sentinel* readers, May-August 1993



CON

Only 16% of patients citing serious problems with their HMOs disenrolled as a result

"The only reason that millions of people are members of an HMO is because prescriptions are free, or only \$5 per prescription. That is the reason I belonged too, but it wasn't worth it." — Jack Krotin, Delray Beach.

Staff graphic: BONNIE LALKY SEIBERT

Records outline status of South Florida HMOs

Three years ago, a *Sun-Sentinel* series exposed flaws in Humana's Gold Plus Plan, the nation's largest HMO for the elderly.

The articles led to congressional audits and hearings, some tightening of HMO quality regulations, and assurances that flaws, from poor care to alleged enrollment fraud, would be fixed.

Humana officials can demonstrate improvements since 1990, including tighter HMO enrollment standards and stepped-up surveillance of the health plan's contract physicians.

But, overall, government promises to rid Florida's growing HMO industry of abuses remain unkept. This new series focuses on seven South Florida HMOs that expect rapid growth as Medicare officials turn to managed care to treat the elderly.

The findings are based on thousands of records. The U.S. Health Care Financing Administration released Medicare files and computer data as a result of Freedom of Information Act requests. Many of these documents have never before been made public.

State agencies that oversee insurance, health-care quality and physician licensing provided access to thousands of pages of complaints and computer data. Reporters reviewed about 500 lawsuits and HMO grievance reports.



Schulte



Keller

Key HMO industry executives and government regulators were interviewed and the HMOs were given a chance to respond to all patient histories cited in the series.

The series also draws on comments from 355 readers who wrote to the newspaper in response to an invitation to share their opinions, pro and con, on Medicare HMOs.

The Florida Atlantic University College of Urban and Public Affairs provided research assistance through Dr. Jay S. Mendell, professor of public administration.

Larry Keller is a general assignment reporter specializing in investigative and consumer stories. He joined the newspaper in 1987.

Fred Schulte is the newspaper's investigations editor. A veteran investigative reporter and editor, he conceived and directed the project.

Grievance reports detail variety of woes

By FRED SCHULTE
and LARRY KELLER
Staff Writers

Louis Waldman claims an HMO doctor botched surgery on his hip, leaving him handicapped and in pain.

His complaint is among more than 400 lawsuits and unresolved grievances filed against South Florida HMOs since 1990 — claims alleging problems ranging from wrongful death to failure to pay millions of dollars in medical bills, records show.

The cases are a tiny fraction of HMO patient complaints. But they reflect growing uncertainty about the legal responsibilities and finances of managed-care plans.

"Many times lawsuits can show a quality of care or a financial issue," said Florida Insurance Commissioner Tom Gallagher.

HMOs must have panels of employees to hear patient grievances. The state keeps no statistics on the outcome of the hearings, but most cases appear to get resolved.

For example, Humana Medical Plans, the state's largest HMO, handled 2,126 grievances during 1992, state records show.

The HMO, with more than 490,000 members statewide, reported only 25 grievances it did not resolve between April and June. Ten reports involved quality of care, and five appealed denied claims. Several others complained about the attitude of HMO personnel or excessive waiting times.

During 1992, Humana estimated potential losses of \$441,000 in grievance claims pressed by 34 people.

Some other HMO disputes — Waldman's lawsuit against Health Options, for example — could prove more costly.

Waldman, 77, and his wife, Lilie, sued the HMO in November 1992. They say the HMO is liable for alleged negligence by Broward orthopedic surgeon Norman Moskowitz.

Moskowitz operated on Lewis Waldman in 1990, but failed to take action to prevent infection, the lawsuit says. Waldman claims he suffered permanent injuries and endured additional surgery as a result. Moskowitz has denied the allegations.

Health Options contends it is not liable for actions of physicians under contract to the HMO.

Whether HMOs are responsible for injuries caused by contract doctors is unclear. At least six malpractice lawsuits asserting this claim were pending against South Florida HMOs as of December 1992, according to annual reports filed by the HMOs. More such suits are expected.

"We'll see this type of case more and more frequently with the prevalence of HMOs," said Health Options attorney Catherine B. Parks. "The issue is far from clear-cut."

Other Florida HMOs have reported pending claims that could result in sizable losses.

Av-Med HMO in October 1992 listed claims the company estimated could cost more than \$744,000. The figure did not include three malpractice lawsuits with huge potential losses.

The claims ranged from a woman who said Av-Med owed her up to \$15,000 for her surgery to a Dade widow who said HMO physicians contributed to her husband's death when they failed to diagnose his tuberculosis. Av-Med denied the allegations.

State regulations require HMOs to post profits of at least 2 percent of gross revenues before taxes. That requirement reflects insurance officials' concern that HMOs facing cash shortfalls might be tempted to refuse or stall needed medical services to save money.

But a *Sun-Sentinel* review of HMO reports filed since 1990 found that state regulators tend to nurse along HMOs that fall short of the threshold. Typically, the HMO simply submits a "corrective action plan" that outlines steps the HMO intends to take to boost revenues.

Av-Med, for example, has failed to meet the standard in 1992 or this year, records show.

Humana also failed to make the 2 percent standard in 1992. Company officials said their Tampa operations dragged down profitability.

With profits now exceeding 5 percent, Humana is in compliance, company officials said.

Matthew L. Carr, M.D., complained to the state in February that CareFlorida HMO owed him several thousand dollars for services he had performed.

Carr, a Lauderdale Lakes heart specialist, accused the HMO of not paying his bills, some for more than a year.

Carr got no satisfaction from the department of insurance. Neither did at least two dozen other doctors who have filed similar grievances against South Florida HMOs since May 1992, state records reveal.

State insurance regulators said they need to step up reviews of HMO payment disputes to make sure shaky finances do not compromise the quality of patient care.

"We need to apply some urgency to looking into these types of things," said Steve Burgess, the insurance department's consumer advocate.

Executor: Couple duped into HMO

When Garrett and Myrtle Detwiler joined Humana's Gold Plus Plan, they probably did not realize it.

Garrett Detwiler had Alzheimer's disease and was senile. Myrtle Detwiler couldn't speak because of a stroke. The executor of their affairs learned they had joined Humana when Medicare began rejecting their medical bills in October 1990.

The Detwilers, who are in their 80s and live in a retirement home in central Florida, were duped into joining Humana, according to the executor, Philip Courter.

Courter complained to state insurance officials, who rely on HMOs to investigate complaints of enrollment abuses. Asked by the state to review the Detwilers' enrollment, Humana found no improprieties. Typically, Humana hires Miami private detective Roberto A. Sasso, a former Humana contract employee, to review complaints of sales abuses.

Each of 20 Sasso reports obtained by the *Sun-Sentinel* found "no conclusive evidence" of sales abuses by Humana agents.

Sasso cut his HMO teeth during the mid-1980s when he served as an assistant to International Medical Centers president Miguel Recarey. IMC collapsed in 1987 amid allegations of enrollment fraud.

As for the Detwilers, their executor persuaded federal officials to place them back on Medicare. Eventually, the federal government, not Humana, reimbursed executor Courter for a few thousand dollars he spent paying some of the Detwilers' bills.

Doctor clashes with clinic administrator

After only four months on the job, the medical director of Pembroke Health Center accused his non-physician partner of caring more about profits than the well-being of HMO patients.

"I am very disgusted with such practices that I consider unprofessional and illegal," Dr. Antonio V. Hernandez wrote in a June 1990 letter to center co-owner Jose Torres.

Hernandez went on to accuse Torres' son of enrolling HMO members too sick to be treated at a general practice center and of interfering with medical treatment decisions.

"These lay people shouldn't be allowed to handle clinics," Hernandez said in an interview. "All they care about is money. They don't care about patients. It's extremely dangerous."

At the time, the clinic saw HMO patients from CareFlorida and Family Health Plan.

Jose Torres Jr. denied the allegations. He referred a reporter to his attorney, who called Hernandez' allegations "sour grapes."

Similar clashes between doctors and lay administrators have surfaced in several lawsuits in South Florida.

Dozens of South Florida HMO centers are owned jointly by physicians and non-physician entrepreneurs, or are owned outright by people with no medical training who hire doctors to treat patients.

HMO charges that doctor overspent, took patients to another plan

Dr. George Laquis thinks he did a fine job treating Humana's Medicare HMO patients. But Humana claims the Coral Springs doctor spent too much money along the way.

Humana is suing Laquis, demanding he repay the HMO \$160,675 — his half of a deficit incurred in caring for Humana patients.

The *Sun-Sentinel* found 13 similar lawsuits in South Florida courts. Some allege that HMOs pressured affiliated

Medicare HMOs lose money if they spend more than the U.S. government allots them for each patient. In South Florida, that is an average of \$500 a month.

doctors to scrimp on medical care to boost profits. Most of the suits were filed by Humana, the state's largest Medicare HMO.

Medicare HMOs lose money if they spend more than the U.S. government allots them for each patient — in

South Florida, an average of about \$500 a month.

Humana also is upset that Laquis took at least 356 Medicare patients with him when he left the health plan in November 1992. The patients switched to PCA Health Plans of Florida

HMO, which Laquis had joined. Laquis declined several requests for comment.

Humana is demanding that Laquis pay \$1,200 for every Medicare member who left Humana with Laquis, a total of \$427,200.

Whether Laquis must pay is unclear. The Third District Court of Appeal ruled last December in a similar suit brought by Humana that such payments were "against public policy," but Humana is appealing.

Patients caught in enrollment battle

Curtis Soles swears CAC Ramsay deceived him into joining its Medicare HMO health plan.

"It was what I'd call an under-the-table deal," said Soles, 71, a retired mechanic.

Soles said he hurriedly signed some forms during a medical appointment. He didn't realize the papers were CAC Ramsay enrollment forms until a Ramsay membership card arrived in the mail a few days later.

Three other patients also stated under oath that Ramsay sales agents deceived them into switching from another HMO, according to affidavits on file in Broward Circuit Court.

CAC Ramsay has since begun calling newly enrolled Medicare members to make sure they understand the HMO plan and want to remain in it, company officials say.

The elderly patients who say CAC Ramsay deceived them were caught in the middle of a nasty sales skirmish between CAC Ramsay and competitor CareFlorida HMO.

CareFlorida claimed in late 1990 that Dr. Mario Rodriguez, who ran Westhills Medical Center in Hollywood, owed the HMO \$434,214 because he had overspent on patient care.

To escape the debt, CareFlorida claimed, Rodriguez sold the medical center to two other doctors. Rodriguez then joined CAC Ramsay and tried to take his patients with him, according to CareFlorida.

But two patients alleged they were talked into dropping CareFlorida by a CAC Ramsay sales agent who told them — falsely — that CareFlorida didn't have the money to pay its doctors. Such sales tactics may violate state laws, which prohibit HMOs from making untrue claims to sign up new members.

Another patient, Florence Rollins, said the CAC Ramsay agent lied to get her business.

On a visit to her home, the agent said she would remain a CareFlorida member if she signed the form he presented her. The form was a CAC Ramsay enrollment application, court records state.

Sales agents pursue mass enrollments

On paper, Esther Perez and John Bartelds were extraordinary Medicare HMO sales agents.

They signed up about 500 Medicare members to CareFlorida's HMO in three weeks, operating from a doctor's office. That's quite a feat, considering that the U.S. government says each enrollment should take one hour, mostly to make sure enrollees understand how HMOs work.

Bartelds told the *Sun-Sentinel* that Dr. Kumar Rajagopalan was ending his contract with Humana's Gold Plus Plan in 1992 and wanted to take his patients with him to another HMO.

Rajagopalan agreed to make appointments to see many Humana patients at Lakeside Medical Center in Tamarac, according to Bartelds. The doctor's purpose, Bartelds said, was to get the seniors into his office where they could sign forms to transfer their HMO enrollment from Humana to CareFlorida.

Rajagopalan denied in an interview that he scheduled patient visits for the purpose of having his patients re-enrolled in another HMO.

But Bartelds said he and fellow sales agent Perez took elderly patients into a private room in groups of ten to persuade them to transfer to CareFlorida. Most switched, he said.

Rajagopalan recalled that Bartelds and Perez — and sales agents from at least two other HMOs — set up shop outside his office once word was out that he was leaving Humana.

"All these companies were here shopping for patients," he said. "They just came on their own. Everybody was just scrambling."

Bartelds contends CareFlorida executives knew of the mass sign-up campaign, but advised him to "do it behind closed doors," an allegation CareFlorida president Larry Kries denied.

Bartelds also says CareFlorida fired him instead of paying him and Perez up to \$50,000 in commissions. He also unsuccessfully sued the HMO last year for age discrimination. Bartelds now sells HMO policies for PCA Health Plans of Florida. Perez did not respond to requests for comment.

Meanwhile, Humana is suing Rajagopalan and CareFlorida, accusing them of stealing the company's patients. Humana executives say they severed ties to Rajagopalan because of concerns over the quality of services at his medical center.

Responded Rajagopalan: "These patients have the right to choose the doctor they want. They wouldn't come back to me if they didn't have confidence in me."

Monitoring of agents lax at times

By FRED SCHULTE
and LARRY KELLER
Staff Writers

Elizabeth Davino said the HMO sales agent who came to her home was so abusive her husband had to kick him out.

Davino said agent Harris Deitch, who was selling an HMO plan owned by Physicians Corporation of America, was upset because she would not sign up on the spot.

"I did not appreciate his attitude, especially in our own home," the West Palm Beach woman wrote in a complaint filed with the Florida Department of Insurance in April.

State officials told the HMO of Deitch's conduct and he was terminated as a result, according to company records. Deitch did not respond to requests for comment.

But insurance regulators took no action against at least 34 HMO agents accused by customers of other sales abuses, records show. *Sun-Sentinel* reporters found the consumer complaints, most filed since 1992, squirreled away in insurance department offices.

"We should be looking at that," said John Black, a Florida Department of Insurance official. "There is no mechanism to track [bad agents]."

Florida insurance officials in Tallahassee are trying to keep tabs on more than 5,000 agents licensed to sell HMO policies, both to Medicare patients and working people.

Some HMOs have vast forces of sales agents who work on commission, generally \$60 or more for each member they sign up.

For example, Lourdes Health Services of Miami — with 30,000 members, mostly in Dade and Broward counties — has more than 500 sales agents.

By contrast, Av-Med HMO — with more than seven times as many members — has only about 100 agents, state records show.

Steve de Montmolin, an Av-Med vice president, said the small sales force is far easier to control.

"I've never heard of any of our brokers going to an old person and trying to get them to switch plans or scare them," he said. "To me, that's predatory."

Being of Medicare age in South Florida can bring an assault from HMO telemarketers, who buy lists of the names and phone numbers of people 65 or over.

After an initial telephone sales pitch, HMOs turn good prospects over to sale agents who visit customers in their homes.

"You huckster these poor people to death," said PCA Health Plans of Florida sales agent John Bartelds. "These people are just beaten to death on the telephone. They shouldn't be badgered. Everybody is just calling these people to death."

Bartelds said South Florida's HMO industry is largely a "big switcho-game," in which each HMO raids patients enrolled with competitors. He thinks that fierce competition breeds abuses.

State reviewers acknowledge they have a tough time ensuring that sales agents fully explain HMO provisions to customers and refrain from making false accusations about competitors or misrepresenting HMO coverage.

"It's not that easy to enforce the law," said insurance department official Black. "You are supposed to sell the product on its merits. I'll be the first to admit that is a little naive."

Florida HMOs say they have taken a number of steps to cut down on enrollment abuses.

Humana Medical Plan "goes to great lengths" to contact new Medicare members to make sure they understand how the system works, said company executive Joe Berding.

Humana has fired about 20 commission sales agents for enrollment abuse since 1987, while allowing others suspected of less serious abuses to resign, Berding said.

Competitor CAC Ramsay has taken a different tack. It has a small staff of agents who are paid a base salary of about \$16,000 plus commissions. Most agents earn from \$30,000 to \$60,000 a year, company officials said.

"Our sales representatives won't get a commission if that member doesn't stay on for at least three months," said Isa Diaz, director of corporate relations for CAC Ramsay. "They're not motivated just to sign people up, but to keep them."

Doctor accused in sex abuse, patient death

Self-described sex addict Dr. Preston Gary Stern treated Av-Med patients for four years, after the HMO failed to heed a warning to check into his past, court records reveal.

The state of Connecticut had revoked Stern's medical license in 1984 after two women made sexual misconduct complaints against him.

But Stern moved to Florida, where he also held a license. In March 1985, the Coral Springs internist joined Av-Med, which asked the American Medical Association to check Stern's background. The AMA sent back a letter in May 1985 advising Av-Med to contact Connecticut officials, but Av-Med failed to do so, court records state.

"They probably should have followed up," said Av-Med attorney Steven Ziegler. "Credentialing has really tightened up in the past five to six years."

In 1985, Stern advised a patient to take too many enemas and laxatives, causing her death from cardiac arrest, according to Florida medical licensing records. His only punishment was a letter of guidance from the state medical board.

Stern also resigned his staff privileges at Northwest Regional Hospital in Margate after the incident and two other Broward hospitals suspended his privileges.

The complaints did not stop. Some patients who sought relief from stomach disorders and other ailments complained of unnecessary breast exams and unwanted sexual overtures in Stern's office or their hospital rooms.

Stern victimized at least six female patients between September 1987 and March 1989, according to Broward prosecutors. One woman ran screaming and half-naked from his office after Stern gave her a pelvic exam.

A patient hospitalized for severe vomiting said Stern did a rectal exam, told her she had "a nice ass," asked her sexual questions and tried to give her a breast exam, records state.

In June 1989, after Stern's aberrant behavior became the target of a criminal investigation, Av-Med terminated his contract. Florida's medical board revoked his license in December 1989.

In 1991, Stern pleaded guilty to sexual battery. Sentenced to three years in prison, he served 15 months. His 10-year probation forbids him from practicing medicine. And he must continue counseling for what he and his therapists have called a sexual addiction.

Physician goes to Georgia after problems

The undercover police officer walked into Dr. Manuel Fajardo's HMO center faking nervousness. The officer left with a bottle of tranquilizers, although he never saw the doctor. Fajardo's wife, Mary, who had no medical training, handed out the pills.

Charging that Fajardo violated medical practice standards, Florida officials suspended his license for six

Dr. Manuel Fajardo said his IMC experience was "painful" and had "ruined" him financially.

months in September 1986. They also imposed a two-year probation. In July 1987, Fajardo signed an agreement with the U.S. Drug Enforcement Administration, promising to keep tighter control over dangerous drugs.

Fajardo, then affiliated with International Medical Centers HMO in Tampa, landed in trouble again in 1988 — this time for endangering Medicare patients for financial gain. Medicare paid Fajardo a fixed fee for each HMO member. When two severely ill patients needed a kidney specialist, Fajardo failed to refer them to one in order to save himself money, state officials alleged. Both patients nearly died as a result of Fajardo's "gross malpractice," the state concluded.

Fajardo surrendered his Florida license in August 1988. He moved to Eastpoint, Ga., near Atlanta. Based on the Florida decision, Georgia officials suspended his license for one month and placed him on two years' probation, which ended in February 1992.

Reached at his Atlanta medical office, Fajardo said his IMC experience was "painful" and had "ruined" him financially. He declined to answer questions about the Florida medical licensing board's complaint, except to say: "Nothing was ever proven against me."

TODAY'S FINDINGS

Dozens of physicians have found work with South Florida Medicare HMOs in recent years despite accusations of poor performance or problems in their pasts.

- HMOs often add hundreds of new doctors each year, making it difficult to check credentials properly
- Humana Medical Plans has terminated 50 physicians for poor performance, and most joined other area HMOs
- South Florida's competitive health care market, in which HMOs court doctors and let them share in profits, tends to undermine HMO quality-assurance efforts



Complaints follow doctor's career

Dr. Manuel N. Luna first ran afoul of Florida's medical licensing board 10 years ago, after he prescribed steroids to treat a neck injury. His patient required a hospital stay for fainting spells and weakness, signs of steroid overdose that Luna should have detected, state officials alleged in a 1983 civil complaint.

Medical officials closed the case in 1984 with a written warning. They advised Luna, then practicing in the central Florida town of Zolfo Springs, that any further missteps would be dealt with severely, records show.

Luna moved to South Florida and joined International Medical Centers HMO, which Humana purchased in late 1987.

Once again, the state medical licensing board found Luna's medical skills wanting. Working at a Humana center in Plantation, Luna failed to diagnose a recurrence of throat cancer in a man with a history of the disease.

Rather than promptly

refer the patient to a specialist, Luna treated the man's sore throat and other symptoms with antibiotics, telling him he had a cold.

Luna took more than 14 months to send the patient to a specialist, who quickly detected throat cancer, according to state records.

The state settled its case against Luna in October 1991 with a reprimand and a \$5,000 fine. Two months later, the board hit Luna with a second fine, of \$3,000, as well as imposing a two-year license probation because he failed to pay the judgment. Humana terminated its contract with Luna after he refused to allow the Humana quality reviewers to inspect his records, company officials confirmed.

The doctor has treated patients for several HMOs in recent years, including PCA Health Plans of Florida and Family Health Plan. Luna would not discuss the state's complaints against him on the advice of his attorney. State officials said Luna agreed in October to relinquish his medical license.

Patients say HMO doctor was abusive

By LARRY KELLER
and FRED SCHULTE
Staff Writers

Humana doctor Andrew Richman rubs some people the wrong way.

Like Vivian Ferns. On a visit to Richman's HMO Center in Tamarac last year, Ferns said she didn't want to live in pain. Richman told her about Jack Kevorkian, the Michigan doctor who assists in suicides, according to a complaint filed with the HMO.

"It was obviously something I wish hadn't been said," said Joe Berding, Humana's South Florida

There are concerns among some Medicare HMO patients that they sometimes are treated shabbily or are harassed by busy HMO doctors and their staffs.

vice president.

Richman says he made the comment in jest. "It was . . . taken out of context," he said.

Ferns, 73, switched to another HMO.

The incident typifies concerns among some Medicare HMO patients that they sometimes are treated shabbily or are harassed by busy HMO doctors and their staffs.

Richman co-owns a dozen Humana HMO centers in Broward and Palm Beach counties. Two other complaints:

■ Gertrude Gross received a letter from Richman's Deerfield Beach clinic saying she had 30 days to obtain "alternative medical care." The reason: Gross' daughter had allegedly been abusive to Richman and his staff while complaining about the level of care afforded Gross.

Gross assumed she had been kicked off Humana and complained to the HMO and to the Department of Insurance. In fact, Richman was trying to move her to another Humana-affiliated medical center.

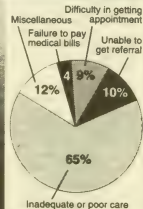
But Gross complained that the move would be a hardship because she didn't drive and couldn't walk long distances.

Eventually, Richman removed himself as medical director at the center and Gross got a new primary care physician there, state records show.

"I remember the daughter being impossible," Richman said. "[She] was pretty much trying to dictate how I practice medicine."

HMO quality complaints

Florida HMO quality complaints most often cite poor medical care or delay getting an appointment with a specialist. Here's a breakdown.*



* The state partially or fully confirmed 54% of the complaints for which data are available.

SOURCE: Sun-Sentinel analysis of Florida Agency for Health Care Administration resolved complaints, 1991-1993.

Staff graphics/BONNIE LALKY-SEIBERT

Richman was informed he violated Humana's procedures for dealing with patient problems, company executive Berding said.

■ Maye Hagan complained in 1988 to the state Department of Business and Professional Regulation that she was released prematurely from a Humana hospital after she was injured in a car accident.

She was a patient at one of Richman's medical centers, although Richman had not treated her.

The state Department of Health and Rehabilitative Services agreed with Hagan's contention about poor care. But in 1991, the DPR cleared Richman of wrongdoing.

That might have ended the episode, but the doctor decided to get in the last word.

"Your attempt to inflict damage on my reputation and inflict hardship on myself, my family and my livelihood has been rebuffed," reads a letter on clinic stationery, signed by Richman and dated Sept. 4, 1991.

"Your totally false accusation ended up where it belonged, in the trash," the letter to Hagan stated.

"For some reason, the woman was after my license," Richman said. "It was almost malicious to me."

Family says PCA plan tried to 'weasel out'

Foreign Service officer Gerald Loftus spent much of his career trying to settle disputes in the Middle East. Now in a new post in Washington, D.C., he is drawing on his diplomatic skills to force a South Florida Medicare HMO to care for his 85-year-old mother.

Ann Loftus of Coral Springs suffered a stroke in June during a visit to her son's home. Her HMO, PCA Health Plans of Florida, paid for a hospital stay in Washington and agreed to cover rehabilitative care there — until the HMO learned

how much it would cost.

Loftus said. "They were trying to weasel out of their responsibility," Loftus said. "You really have to twist their arms to get anything."

Loftus said the HMO gave him two choices: put his mother, who was partially paralyzed from the stroke, aboard a commercial flight, or pay out of his pocket for an air ambulance to bring her back to Florida for treatment.

Loftus protested to U.S. Health Care Financing Administration officials in Atlanta, who agreed to

intervene. Within 24 hours, the HMO relented and paid for an air ambulance, Loftus said.

PCA's chief medical officer, Dr. Glen Johnson, disputed Loftus' account. Loftus "agreed with what we were doing," Johnson said.

The HMO found Ann Loftus a bed at a nursing home in Homestead, an area devastated by Hurricane Andrew. She has since been discharged. Loftus is arguing with the HMO over how much at-home care she will get to help her regain use of her arms.

Dispute forces patient to turn to aid panel

When a Broward man fainted in January 1991, he began a painfully long billing dispute that led him to one of Florida's lesser-known consumer protection agencies.

Doctors admitted the man, who is not named in state records, to Humana Hospital Bennett in Plantation. Four days and \$11,000 in billings later, he left the hospital against doctors' advice, the cause of his blackout still unexplained.

The man's insurer, Av-Med HMO, paid the hospital. But, 10 months later, he got a letter from a collection agency demanding he reimburse Av-Med.

He appealed to Av-Med's grievance committee, which in August 1992 agreed to dismiss the matter. Despite that action, Av-Med rescinded its payment to the hospital. The hospital then began billing the patient.

The man turned to

Florida's six-member HMO subscriber assistance panel. Part of the Department of Insurance, the panel travels around the state and hears unresolved HMO

grievances every three months. It takes about three months to get a hearing.

The HMOs settle about 30 percent of complaints once they are notified that a hearing will be held on the dispute, said panel member Steve Burgess, the insurance department's consumer advocate.

Burgess supplied the *Sun-Sentinel* with a sampling of HMO cases recently heard by the panel. Ten of the 16 cases were decided in favor of the HMO member. The panel's recommendations are not binding, but Florida HMOs usually agree to abide by the panel's findings.

In the unnamed man's case, the panel not only concluded that he should pay the Humana hospital no money, it also expressed concern that he had waited four hours in the hospital emergency room without treatment until it was determined he had insurance.

Woman fights 8 months to get \$60 returned

It took Gail Engebretson eight months, 31 phone calls and a lot of aggravation before she got Humana to reimburse her family for premiums paid in advance by her father, who had died.

All she wanted was \$60. Engebretson's father, Rinaldo Marinello, 78, of New Port Richey, was vacationing in the Midwest in September 1990 when he was hospitalized with pneumonia. Within three days, he had suffered a stroke, broken an arm in a fall and died.

The following month, while helping her mother with affairs in Florida, Engebretson contacted Humana about disenrolling her father and getting a \$60 refund of three months of insurance premiums he had paid in advance.

Unlike South Florida, where Medicare HMO members pay no premiums, HMOs on Florida's west coast collect a monthly fee.

Humana told Engebretson, who lives in Wisconsin, to send the company her father's death certificate. She did, but two months later, when she still hadn't gotten a refund, she began logging her phone calls.

Between Dec. 28, 1990, and June 25, 1991, Engebretson made 31 phone calls to Humana, the U.S. Social Security Administration, the Florida Department of Insurance and other agencies, according to her records.

"We have found [Humana] to be unhelpful and rude on numerous occasions," she wrote in a letter to the Florida Department of Insurance. "They have hung up on me more than once."

"If this is the manner in which companies treat their customers, I can't get my mother and her assets out of Florida fast enough."

On July 1, 1991 — nearly nine months after Engebretson began bugging Humana — the company refunded her father's premiums.

TODAY'S FINDINGS

Patients with complaints about HMOs find that state law and the regulators paid to uphold them often side with the HMO industry.

■ HMO patient grievances take months to settle and many people feel as if they never get an adequate hearing.

■ An obscure state law forbids adults from suing for the wrongful death of a parent. Critics think the law insulates Medicare HMOs from having to pay damages should they be negligent.

■ Many key records that could help consumers judge the quality of competing Medicare HMOs are kept confidential.



Reports on care not available to consumers

By FRED SCHULTE
and LARRY KELLER
Staff Writers

A group of doctors in Tampa will spend \$26 million in tax money over three years to review the quality of care given to Medicare patients, including HMO members.

But don't expect to hear the results.

Their reports are confidential — even though they might help elderly people decide which HMOs offer the best care.

The medical-review group's secrecy mandate is so strict that families of Medicare patients who die from, or are injured by, a physician's error can be told the whole truth only if the guilty doctor agrees.

"Most doctors don't want everything mentioned," conceded the group's medical director, Dr Robert A. Turkel.

The U.S. Health Care Financing Administration pays Turkel's group, Florida Medical Quality Assurance Inc., to investigate medical quality complaints. It has reviewed 3,000 Medicare HMO cases in the past 18 months. But Turkel said federal regulations forbid him from discussing the findings.

Turkel's group, called a peer review organization, presents its findings to doctors whose care it evaluates and encourages them to improve their practice methods.

"If we gave out information [to patients] we could be dragged into lawsuits," he said.

Studying HMOs in Florida, Sun-Sentinel reporters found that other key medical quality indicators remain hidden from patients, or are largely ignored by regulators.

For example, HMOs must file annual reports listing unusual deaths, injuries and other problems. These reports are filed with the Florida Agency for Health Care Administration in Tallahassee.

The agency has never examined the data to detect HMO patient death or injury trends, officials acknowledge. The incident reports are confidential under state law.

"Maybe we should open up those records," said Doug Cook, who heads the health care agency. "People have a right to know when their health and lives are concerned."

HMOs must advise the same agency of HMO doctors responsible for serious treatment blunders. The health administration agency is supposed to send the names to the Department of Business and Professional Regulation, which can revoke a physician's license.

Physician reports submitted by

LONG WAIT

Many HMO patients think the grievance process takes far too long to resolve disputes or is stacked against them. Here are some figures from agencies involved in the process.

- Quality of care complaint investigations by the Florida Agency for Health Care Administration take on average four months to resolve.
- The U.S. Health Care Financing Administration takes on average four months to resolve complaints about Medicare HMO enrollees and about six months to finish reviewing complaints alleging poor quality of care.
- Medicare HMO patients must appeal an HMO's decision to refuse payment for medical services to a company in New York state. The company sides with the HMO in 50 percent of payment disputes.
- The Florida Department of Insurance HMO subscriber assistance panel, which hears HMO grievances, backed the HMO in 10 of 16 cases examined.



SOURCE: Sun-Sentinel computer analysis of Florida Agency for Health Care Administration, Department of Insurance and U.S. Health Care Financing Administration computer data

HMOs cannot be made public, whether or not any action is taken against the doctor. By contrast, many files involving private practice doctors who face disciplinary actions are available for public viewing.

Neither state nor federal government officials, who are under pressure to boost HMO enrollment as a means to cut costs, have ordered HMOs to submit medical quality data for public scrutiny.

"The HMOs can provide this data," said a U.S. Health Care Financing Administration official, "but HCFA doesn't want it. If HCFA got that data, it would be very easy for patients to compare the performance of one HMO to another."

Cook said that state officials must do a better job of getting medical quality information out of agency computers and into the hands of consumers.

Humana Medical Plans executive Joe Berding agreed.

"If it is an objective measure, I'd like it to be public," he said.

Doctor accused of prescription; records problems

Fifteen years ago, Dr. Jerome Rotstein sat in federal prison for falsifying drug research results. That didn't stop him from practicing for years in South Florida, until the state suspended his medical license last month.

Rotstein, an internist with an office in Tamarac — and until March, in Hallandale — has treated patients for PCA Health Plans of Florida, Av-Med, Family Health Plan and Lourdes Health Services HMOs in recent years. He said he no longer is affiliated with any HMOs.

Rotstein worked in New York as a consultant for drug companies during the 1970s. In 1978, he pleaded guilty to charges of making fraudulent statements to the U.S. Food and Drug Administration. He got six months in prison, followed by two years of probation, records show.

In 1979, Rotstein moved to South Florida, where he opened a health-care practice. Florida medical officials immediately tried to revoke his license, but Rotstein argued his crime was a misdemeanor under Florida law and thus not grounds for revocation. An appeals court agreed and

let him keep practicing.

Controversy trailed Rotstein, however.

Florida officials accused him in 1990 of failing to keep proper medical records, improperly prescribing drugs, and malpractice in the care of five patients.

Rotstein operated on a patient without documenting the need for the surgery, then altered the records to justify the procedure, the state alleged in an administrative complaint.

"I never did an operation in my life," Rotstein told the *Sun-Sentinel*.

In another case, the state alleged a woman died after Rotstein failed to use antibiotics to treat her raging fever. Rotstein's records indicated the patient's health was improving. He denies the charges.

Rotstein also was accused of prescribing dangerous drugs recklessly. Between June 1986 and January 1988 he provided more than 2,200 tablets of Dilaudid — a powerful narcotic painkiller — to a patient he knew was a drug addict, according to state medical files.

"If I knew he was a drug addict, I certainly wouldn't prescribe Dilaudids,"

Rotstein said.

Further doubts about Rotstein arose. A 1990 lawsuit alleged Rotstein doctored patient records to conceal malpractice. A former CIA documents expert testified the charts had been altered. Rotstein settled the suit last year.

The terms are confidential. Rotstein denied altering the patient's records. Yet a state medical-licensing panel earlier this year found probable cause to believe Rotstein violated state licensing statutes. The matter is pending.

Another of Rotstein's patients killed himself in April with drugs prescribed by the doctor. The man was found in a Broward motel room clutching a near-empty bottle of painkillers. Rotstein prescribed nearly 2,300 pills to the man in a 10-month period, according to state records.

State officials in June issued an emergency order to stop Rotstein from prescribing abusive drugs. Last month, they suspended his license after inquiries by the *Sun-Sentinel*. Rotstein faces a formal state hearing and possible revocation of his license. No date has been set.

HMO decides not to pay for days in hospital

Shortly after Harry Fader signed up with PCA Health Plans of Florida HMO in January, he landed in Wellington Regional Medical Center near West Palm Beach. He had gone to the emergency room with stomach pain and weakness on the advice of his PCA doctor, who thought he might be suffering from overuse of steroid drugs, which he was using to treat an existing ailment.

Fader, who is diabetic, underwent a number of tests before doctors discharged him to a nursing home to recuperate. He has since recovered.

"We didn't decide when to admit Harry, nor did we decide when to release him. These decisions were made by the PCA-affiliated doctors and the hospital staff, not by us."

— Evelyn Fader

But his family is incensed over PCA's decision — rendered after Fader had been discharged — not to pay for five of the days he spent in the hospital. PCA's decision left the family on the hook for the bill. PCA says it did not pay for three days.

"We didn't decide when to admit Harry, nor did we decide when to release him," Fader's wife, Evelyn, wrote to the Florida Department of Insurance in April. "These decisions were made by the PCA-affiliated doctors and the hospital staff, not by us."

Fader fought back. PCA referred the dispute to an arbitration panel called the Network Design Group in Pittsford, N.Y.

The group handles appeals of HMO payment disputes for Medicare beneficiaries. It sides with HMO in about 60 percent of cases, according to company officials. In Fader's case, the Network Design Group sided with him.

Fader was "not receiving any care that needed to be rendered in the hospital," responded Dr. Glen Johnson, PCA's chief medical officer. He said the HMO lost its appeal because it could not document notifying Fader of its decision.

HMO stays alive

despite woes

Complaints, cash troubles mark plan

By LARRY KELLER
and FRED SCHULTE
Staff Writers

It's one of Florida's tiniest HMOs, but Clinica Fatima in Miami has some of the industry's biggest troubles.

The health plan, partly owned by the father of state Rep. Bruno Barreiro Jr., R-Miami, has stayed alive despite anemic finances and repeated violations of state HMO standards.

Most recently, top insurance officials realized the cash-poor HMO was paying \$2,000 a month to Barreiro.

"I help out in troubleshooting and contracting with physicians," the legislator said. "It's a little less than a part-time job."

An aide to Insurance Commissioner Tom Gallagher said last week that he was suspending the payments to Barreiro because insurance department officials were unsure what the legislator was doing to earn the money.

Other problems at the Little Havana health plan:

- Between 1990 and this year, the HMO's annual cash reserves fell short of state requirements. State officials permitted the clinic to remain open, but this year insisted that it seek investors.

- Clinica Fatima dropped its malpractice insurance in July 1992, leaving it unprotected should patients suffer from medical negligence. The insurance was not in force for nine months.

- In the past year, Fatima has lost more than 800 members — nearly 30 percent of its total.

- Fatima has refused to pay hospital bills by claiming the patients' illnesses predated their joining the HMO.

And last week, state officials received a report from Fatima showing the HMO was \$150,000 short of its minimum operating budget.

"We have them on a pretty tight rope," said John Black, Gallagher's chief HMO regulator.

Black also said Barreiro would not be permitted to draw money from the HMO unless he can show he provides a service.

The state also is holding up payments to Barreiro's father and mother, who are set to earn \$240,000 from the HMO over the next five years. State officials took the action after learning

the *Sun-Sentinel* was preparing an article disclosing the arrangements.

"They're taking money out of this [HMO] that is supposed to be for treatment of patients," Black said.

Barreiro defended the payments. He said his father, Bruno Sr., performs public relations and other duties for the HMO, and his mother works in patient relations. The sale agreement stated that Alicia Barreiro would work no more than four hours a day, five days a week.

"We work at that center and we are very involved," the legislator said.

Rep. Barreiro, who was elected to the Florida Legislature in 1992, was listed as Fatima's corporate secretary in a March 1993 financial report to insurance officials.

He represented the HMO in correspondence filed with the state insurance department and was the HMO ad-

ministrators until his father sold 85 percent of the company to investors earlier this year.

Rep. Barreiro said his role as clinic administrator ended with the sale of the HMO, which the new investors renamed Max A Med. Under the sale agreement, he draws a salary of \$2,000 a month for the next five years.

In the mid-1980s, Clinica Fatima was an affiliate of scandal-racked International Medical Centers HMO. Humana bought IMC in 1987 and continued to contract with Fatima.

While treating patients for Humana, Fatima had about 2,000 members enrolled in its own HMO health plan.

In May, the state insurance department approved the sale of 75 percent of Fatima to Isadore Schwartz, of Virginia. Clara Oliver, of North Miami, bought 10 percent.

Bruno Barreiro Sr. retained a 15 percent interest in the company, records show.

The new investors agreed to pump in \$750,000, said Larry Daniels, a state insurance analyst.

The deal satisfied the insurance department.

Several Fatima patients have problems with the HMO, records show.

When Fatima member Dominique Innocent was treated for lung problems at the University of Miami School of Medicine in 1991, Fatima refused to pay his bills.

The HMO said that Innocent, 62, of Miami, had a kidney transplant before joining Fatima. That, claims Fatima, was a pre-existing condition that disqualified him from coverage at the university hospital.

The hospital is still trying to get Fatima to pay more than \$16,000 in bills incurred by Innocent.

TACTICS UNDER FIRE

Florida HMOs are taking advantage of weak or unclear state laws to avoid paying members' medical bills, a *Sun-Sentinel* investigation has found. Several of the financial practices uncovered by the newspaper, involving both Medicare recipients and working people, surprised State Department of Insurance officials. They promised to crack down on HMO abuses.

HOSPITAL PAYMENT DENIAL

Action: An HMO tells a hospitalized patient the HMO will pay for only a set number of days. Additional days may be billed to the patient — even if an HMO doctor had approved the longer stay.

The Law: State law forbids HMOs from overruling doctors' treatment decisions, but HMO medical directors can deny payment for any services they deem unnecessary.

Patient Story: Eva Signor's doctor at the PCA Quality Care Medicare HMO approved her admission to Plantation General Hospital in September 1992. She stayed 10 days, but PCA decided to pay for only eight. The hospital billed Signor for the difference — \$1,380 — and turned the bill over to a collection agency when she did not pay. Said Signor: "I would not have stayed in the hospital knowing that I did not have the money to pay for it."

HMO Response: PCA officials say Signor stayed longer than was necessary in the hospital. "She was receiving care that could easily be received at home or in a nursing home," said the HMO's chief medical officer, Dr. Glen Johnson.



PRE-EXISTING CONDITION

Action: An HMO claims a disease existed prior to HMO enrollment and refuses to pay for its treatment.

The Law: State law forbids HMOs from kicking members out once they get sick or require medical care.

Patient Story: Sheila Rosenfeld of Hallandale joined the Lourdes Health Services HMO in 1991. Ten months later, Lourdes disenrolled her after she had an abnormal mammogram. The HMO claimed she had not revealed prior mammograms and a benign cyst on her application. Yet a doctor stated that Rosenfeld's breast cancer was unrelated to her cyst or any pre-existing condition. She is still fighting to force Lourdes to pay for surgery and radiation therapy from 1992.



PREMIUM PAYMENT DISPUTE

Action: An HMO appears to have expelled a member with a costly medical condition by waiting past the member's renewal date to mail out a premium notice.

The Law: State law requires HMOs to give subscribers a "grace period" of up to 10 days to pay premiums, but the HMO can cancel members for non-payment after that.

Patient Story: Sherri Hernandez joined CAC Ram-say in January 1991. For a year, her monthly premium statements arrived about two weeks before the due date. After CAC learned she was pregnant, her statements began arriving late or not at all, said Hernandez, of North Miami Beach. She received her May 1992 statement nine days after the payment due date. She mailed her check the next day, but it was returned by CAC, which then kicked her out for late payment. CAC reinstated Hernandez after her employer complained to state insurance officials.

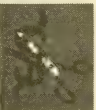


RETROACTIVE BILLING

Action: An HMO wants to recoup a past overpayment. So it deducts the amount in dispute from a pending payment to doctors or hospitals, leaving patients caught in the middle.

The Law: State law forbids doctors from billing HMO patients to supplement HMO payments, but some doctors don the patient anyway. Hospitals are permitted to seek payments from patients.

Patient Story: Raymond Wexler, a retired Broward County plumbing inspector, died of malignant melanoma in Memorial Hospital in October 1992, just a month after doctors found the cancer. His widow, Eunice Wexler of Coconut Creek, could not settle his estate while the hospital and Humana fought over the bill. The HMO deducted a previous overpayment from its \$4,000 check to the hospital. The hospital rejected the payment and tried to collect from the estate. Wexler had to hire a lawyer to straighten out the mess.



HMO FRANCHISE PAYMENT DISPUTE

Action: An HMO requires its affiliated medical centers to assume responsibility for paying members' bills. Some HMO centers are too small to absorb large losses and may appear to stall, or refuse to pay medical bills.

The Law: State law prohibits HMO affiliates from operating as insurance companies by taking on financial risks. But the state insurance department has not enforced the law.

Patient Story: Manuel Burgess, 86, of Tamarac, underwent a highly specialized heart operation in 1992 at Methodist Hospital in Houston after his doctors in Florida decided it was the only place he could have the surgery safely. His Humana Gold Plus Plan-affiliated center, SCMC Services in Fort Lauderdale, refused to pay the bill of more than \$200,000. SCMC claimed Burgess agreed in advance to pay. Burgess sued. Humana recently agreed to pick up the tab — a year after Burgess underwent the surgery.

HMO Response: Humana official Joe Berding said the bill should have been paid sooner.



THROUGH THE CRACKS

Patients say plan abandoned them when they needed health care most.

By LARRY KELLER
and FRED SCHULTE
Staff Writers

When Carlos Miro arrived at Lourdes Health Services HMO in Miami complaining of dizziness, headaches, insomnia and cold sweats, his doctor tried to put him right in the hospital.

But a supervising Lourdes physician refused, "since too many of their patients had been hospitalized that month, resulting in too many costs and expenses," Miro alleges in a lawsuit filed in July.

Miro's doctor admitted him anyway. Miro lay in the hospital for a week and learned he suffered from a rare form of leukemia that requires lifelong treatment.

Lourdes then canceled Miro's policy because of his "claims history and high-risk health condition," and refused to pay the hospital bill, according to the suit.

Since he was dropped from the plan, Miro, 36, a watch repairman, has been unable to find comparable health insurance coverage because of his condition, he says.

Lourdes, which in September changed its name to Advantage Health Plans, is the target of more than two dozen lawsuits filed since last year alleging that patients were kicked out, or their bills went unpaid.

For more than 15 years, Angel De Varona and his wife, Elcida, paid monthly premiums to Lourdes. But when Elcida De Varona needed costly surgery and other medical treatment for uterine cancer, the company refused to pay. The cost: More than \$40,000.

Lourdes canceled the couple's contract, saying their monthly premium had arrived late.

The De Varonas don't deny the late payment. But they say they had been late in the past. They claim Lourdes was willing to accept occasional late payments as long as they didn't develop costly medical problems.

Lourdes also refuses to pay Elcida De Varona's medical bills because, the company says, she was treated at a hospital not affiliated with the HMO and did not exhaust all of Lourdes' internal grievance procedures before filing the suit.

Five weeks after joining Lourdes, Laura Vitucci began feeling dizzy and nauseated. For a month, Lourdes-affiliated doctors were unable to find the cause of her symptoms.

When a neurologist agreed to give the North Miami Beach woman a CAT scan, he detected a malignant brain tumor. Vitucci, then 24, underwent surgery in February 1992.

But Lourdes refused to pay for the surgery or post-operative care such as radiation therapy, saying it was not covered under the medical plan because Vitucci's condition was pre-existing.

Adding to the medical costs, Vitucci's radiation therapy made it impossible for her to swallow, requiring further hospitalization.

She has borrowed money to pay some of her medical bills, which her attorney says are more than \$50,000. She has been unable to pay many others, damaging her credit rating.

A week after her surgery, Vitucci filed a grievance with Lourdes over its failure to cover her illness. She received no response. A year later, after Lourdes said it never received her letter, Vitucci sent the company another one.

She is still awaiting a reply. In the meantime, Vitucci has sued Lourdes for breach of contract.

Warning to travelers: Better not get sick out of state



Staff photo / JUDY SLOAN REICH



“It was an accident. They should have paid [the bill] immediately.”

—Robert Falke, HMO subscriber

It took CareFlorida eight months to pay these bills.

Florida Medicare HMO patients who get sick out of state may find that their HMO refuses to pay hospital or medical bills unless the HMO is convinced that the treatment was an emergency or urgently needed. When the HMO refuses

payment, patients can get stuck with thousands of dollars in bills or may be hounded by bill collection agencies while the HMO bickers over who should pay. Here are some examples:

Robert Falke, 91

- **Residence:** Delray Beach
- **HMO:** CareFlorida
- **Scenario:** Became dizzy and weak after falling backward down a flight of stairs in Baltimore last year. Primary care physician in Florida authorized medical tests in Maryland, but CareFlorida refused to pay the bills.
- **Bill:** \$1,616
- **Outcome:** CareFlorida paid the bill eight months after the injury

Armas Ohman, 84

- **Residence:** Lake Worth
- **HMO:** Humana
- **Scenario:** Fell ill during a visit to Alaska and could not urinate. Too feeble to return to Florida, he had prostate surgery in Fairbanks. Humana said the surgery was not an emergency and refused to pay. Ohman died last year.
- **Bill:** More than \$6,100
- **Outcome:** It took more than a year for Humana to pay most of the bill

Betty Schaffer, 73

- **Residence:** Homestead
- **HMO:** CareFlorida
- **Scenario:** Schaffer's husband suffered a stroke in North Carolina that left him partially paralyzed. They returned home in November to discover that Hurricane Andrew had destroyed their home.
- **Bill:** More than \$3,300
- **Outcome:** CareFlorida agreed to pay, but only after Schaffer complained to the state insurance department

Alice Weiner, 73

- **Residence:** Sunrise
- **HMO:** Humana
- **Scenario:** On a trip to New Jersey, Weiner left the room spin and a "thump" in her chest. "Paramedics took her to the hospital and admitted her. She was diagnosed with a heart attack. Treatment was not an emergency and refused to pay.
- **Bill:** \$2,023.27
- **Outcome:** Weiner won her appeal

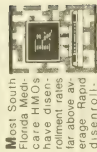
Francis P. Sheridan, 65

- **Residence:** Fort Lauderdale
- **HMO:** Caring Transitions
- **Scenario:** Sheridan went to Las Vegas. Sheridan developed severe breathing problems. He called his physician in Fort Lauderdale, who told him to go to the nearest emergency room. CAC Ramsay spent in a hospital intensive care unit.
- **Bill:** Not available
- **Outcome:** Unresolved

Donna Short

- **Residence:** Hollywood
- **HMO:** CAC Ramsay
- **Scenario:** Short spent 10 days in a Birmingham, N.Y. hospital. CAC refused to pay, saying that it had not authorized the stay. While the bill was in dispute, Short was turned over to a collection agency.
- **Bill:** \$3,933.81
- **Outcome:** CAC Ramsay agreed to pay the bill nine months later

HMO DROPOUTS

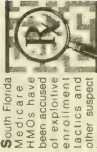


Most South Florida Medicare HMOs have disenrollment rates far above average. Rapid disenrollments, within four months of joining, may indicate poor service or other problems. Here are how local HMOs fared in 1992.

- **U.S. Average:** 9%
- **Av. Med:** 5%
- **CAC Ramsay:** 24%
- **CareFlorida:** 20%
- **Family Health Plan:** 92%
- **Humana Options:** 12%
- **Humana:** 12%
- **PCA Qualicare:** 48%

SOURCE: Sun-Sentinel analysis of U.S. Health Care Financing Administration computer data, July 1993

TODAY'S FINDINGS



South Florida Medicare HMOs have been accused of exploitive enrollment tactics and other suspect business practices, tactics that leave some elderly members beset by bill collectors or worried that they may be denied medical care.

Rapid disenrollments, a key indicator of abusive sales activities, have been a national average in several areas HMOs.

HMOs have al disputes, including refusal to pay more than \$14 million in medical bills, have more than doubled since 1989 and are continuing to grow.

Cash bonuses paid to HMO doctors for holding down costs have raised ethical questions within the

Staff turnover may hurt quality of care

■ Third in a series.

By FRED SCHULTE
and LARRY KELLER
Staff Writers

When Humana Medical Plans cut ties to Romeo Acosta — a doctor Humana accused of providing poor-quality care — he simply moved to a new South Florida HMO.

Acosta joined Heritage HMO. In 1991, the state suspended his medical license amid charges of incompetence. Physicians have found work with South Florida Medicare HMOs in recent years despite accusations of substandard performance, a *Sun-Sentinel* investigation found.

The health maintenance organizations are vulnerable to problem physicians because of rampant turnover, incentives that reward doctors who slash patients' care costs and keep records show.

Among the findings: ■ South Florida HMOs often add hundreds of doctors each year, and in some years as many as 20 percent of the medical personnel are newcomers.

■ Humana, the state's largest HMO, has terminated 50 primary care physicians for poor performance since late 1987. HMOs, the doctors joined other curatives. ■ South Florida's super-competitive health care market — in which rival HMOs eagerly court doctors and give them a share in profits — may tempt some health plans to overlook physician-hiring standards.

"This is not good for patients, and it is not good for the [HMO] industry," said Luis Lameira, president of CAC Ramsay HMO.

Acosta said he co-owns Downstate Medical Center in Lauderdale-by-the-Sea, a 100-bed hospital. He recently accepted a job with Humana, which purchased Heritage in 1989, and CAC Ramsay HMOs.

"I'm not seeing patients. I'm just doing the business work," said Acosta, who denied ever rendering poor medical care.

Acosta's run-ins with state medical regulators date to 1985, when Downstate was affiliated with International Medical Center, an HMO that then under fire for shoddy medical care.

The 1985 civil complaint filed by the Florida Department of Business and Professional Regulation alleged that Acosta failed to properly diagnose a woman who had suffered a stroke.

The patient had suffered abdominal pain for two months. On a visit to the doctor's office in November 1985, the woman complained of weakness and numbness in her legs. Ten days later, she was found comatose at home, records show.

The complaint took three years to wind its way through the state administrative hearing process.

In October 1988, Acosta agreed to pay a \$2,000 fine to settle the case. He also accepted a reprimand, four years' probation and an order to work under the supervision of another physician.

Acosta failed to report to the supervisor, and in July 1991 the board fined him \$1,000 and sus-

A CAC Ramsay van drops a patient off at Miami Beach clinic. Ramsay's president says movement of doctors is a "substantial problem" for the HMO industry.

Reader views

Sun-Sentinel readers disagree whether Medicare HMOs limit access to medical services, or provide the same amount of care as doctors who bill for each service.

PRO

38% of happy HMO members credited HMO doctors with curing them of a serious illness without regard to the cost.

"This is the very best medical solution to us elderly people. Free medication, visits, dental care, anything you can think of, is taken care of free. It is a blessing for us." — Irving Salzman, Sunrise.

CON

48% of unhappy HMO members complained of delays in seeing doctors for necessary treatment.

"It seems that most doctors who belong to HMOs are quite inferior and treat their patients as third-class citizens. They try to avoid giving you referrals to specialists, as in most HMOs the visits to specialists come out of their pockets." — N. M. Mayer, Hollandale.

Source: Letters from *Sun-Sentinel* readers, May-August 1993



state also specifies that a doctor other than Acosta will treat the patient.

The state's case against Acosta points to a business side of HMO medicine many in the industry prefer not to discuss. That HMO doctors may get paid more for providing less care.

Three of the four patients cited in the complaint allegedly were ordered referrals to specialists or diagnostic tests — both of which might have taken money out of Acosta's pocket.

Under Florida law, doctors can be charged with financial exploitation of patients for failing to perform necessary medical tests that might cost them money. But that rarely happens, despite evidence that some HMO doctors have placed desire for profits ahead of patients' medical needs. Acosta found five HMO physicians may have denied or delayed medical care for financial gain. None was charged with exploiting patients, records show.

"Some cases we see are so obvious that [medical] tests weren't done for purely economic reasons," said Dr. Zachariah Zachariah, former head of the Florida Board of Medical Practice. He said doctors fear that HMOs will brand doctors who complain about cost-cutting as "troublemakers" and will sever ties with them.

Internist Preston Gary Stern, who sexually abused female patients, is one such doctor. He served 15 months in prison during 1991 on sexual battery charges and his license was revoked.

Av Med HMO, which prides itself on tough credentialing standards for its doctors, had to admit in court papers that its then-owners failed to act on warnings to check out Stern's background before contracting for his services.

When a patient sued Av-Med, claiming the HMO was liable for Stern's misdeeds, the HMO claimed Stern held a valid Florida medical license and that was all he needed.

Physician turnover in HMOs can be traumatic for patients even when the doctors are highly skilled.

Many *Sun-Sentinel* readers who wrote to the newspaper said they were upset to be bounced from doctor to doctor for reasons that rarely had been explained to them.

Medicare HMO member John Bruno, for example,

Bruno was willing to stick with the doctor he liked and respected, even if it meant traveling more than 20 miles to medical appointments.

When Dr. Jean Pierre Levy joined Family Health Plan HMO, Bruno did too. The Fort Lauderdale resident, who is 71, simply made the trip to Levy's Hallandale office.

But on Aug. 3, Bruno got a letter from Levy, who reported that the HMO had switched Bruno to the care of another doctor. Levy said he would no longer contract with HMOs until he found one that "would treat their patients with respect and dignity."

bers. Doctors often sue for breach of contract, which runs up legal bills. And public airing of quality concerns in the courts can damage an HMO's reputation.

CAC Ramo's executive Lamaia said HMOs also might face antitrust lawsuits if they share quality assurance information that could blacklist doctors.

Many South Florida HMOs take on hundreds of new doctors each year — sometimes keeping up with increasing enrollment and sometimes not, records show.

So pervasive is physician turnover that state officials discard HMO medical provider lists routinely, knowing the lists are obsolete by the time they are filed.

For example, only 106 of the 194 Broward Humana primary care doctors listed in late 1990 were still listed this spring. In Palm Beach County, 50 of 94 primary care physicians remained. The causes of turnover are varied.

Sometimes, doctors — usually specialists — get fed up with HMOs not paying them promptly. Other doctors think HMO cost-cutting interferes with their medical judgment.

While HMOs often anger doctors, they need many of them on their rosters as a selling point. Geographic balance also is important so patients won't have to travel long distances to get care.

The economic needs can clash with efforts to weed out bad doctors.

Joe Berding, Humana's chief executive in South Florida, keeps a Louisville Slugger baseball bat near his desk. It is more than a reminder of his hometown and Humana's headquarters. During a recent interview, Berding picked up the bat, took a swing and joked that he was taking aim at bad doctors.

Berding has taken a number of swings at doctors. Humana has terminated 50 practitioners since 1987 because of concerns over the quality of medical care. Most of the doctors worked in HMO centers that can have more than 1,000 patients.

And most of the doctors quickly signed with other HMOs — often taking large numbers of Humana patients with them.

"It's been a source of frustration for us," Berding said. "We terminate these people, and they go to the competition."

Humana's quality assurance chief, Dr. William Bennett, said some of the doctors had been caught by HMO auditors falsifying patient records to cover up treatment errors.

Other doctors have been guilty of withholding medical services for financial gain, Bennett conceded.

Still, terminating a physician who endangers patients "is a big headache," Berding said. It often means the HMO will lose mem-

Plan's controls help raise quality, physician says

By FRED SCHULTE

Staff Writer

Dr. Debra Gutterman has only good things to say about Humana Medical Plan and the quality of its health-care system, and my office doing high-quality medical care," she said. "They keep us performing at our best."

Gutterman, medical director of Humana's Atrium Plaza center in Plantation, is one of four doctors responsible for 3,800 patients. A doctor in charge of the Gold Plus Medicare plan.

She said Humana's quality controls are far more thorough than other HMOs she has worked for.

Humana reviewers routinely check patient files, usually 25 per doctor, to make sure the care patients receive is better and more appropriate than the care given by the HMO looking over her shoulder.

"Our patients trust us with their lives. They want to know that

when they are sick, their doctors are there," Gutterman said.

All HMOs are required to have quality assurance programs that check the credentials of doctors and review their performance. HMOs also audit files to make sure patients are not placed in hospitals unnecessarily and receive approval from supervisors before a general practice doctor can send a patient to a specialist.

HMOs impose these controls to hold down costs. The HMO system, in which health plans are paid a flat fee for each patient per month, discourages expensive medical practices. In standard practice, doctors are paid for each service they provide, a system that leads to waste and overuse of medical care, HMOs contend.

"We would like to think we are practicing a better and more appropriate than the care given to the community," said Humana's quality-assurance chief, Dr. William Bennett.

were paid by the federal government on average about \$300 a month, he said.

Others blamed the payment system for encouraging doctors to delay or deny medical care.

Some were just plain angry. "I went in well and left a person who could have died and they didn't give me any help," said Stanley, a 67-year-old man who said he had called Humana Gold Plus Plan when her doctors kept cutting back on her

medication.

"Everything was going fine until I got sick," said Richard Lundo, a 60-year-old former Humana member.

Other HMO enrollees — especially those enrolled in Humana — said they were happy.

"I could get no better care than if I were a millionaire," said Humana Gold Plus member Stanley Bennett.

"They've treated me like a

king," said another Humana member, Hugh Doyle.

HMO members aren't the only ones calling to comment on the plan, however. "I've been asked to be identified for fear of losing his HMO contracts."

These HMOs have effectively made it possible to locate as close as possible to these patients, and ... I don't like it."

The *Sun-Sentinel* is attempting to answer all HMO messages left with reporters. Please be patient.

Medicare officials pledge to look into readers' complaints

By FRED SCHULTE
Staff Writer

Medicare officials in Atlanta on Tuesday promised to look into complaints about Medicare services voiced by *Sun-Sentinel* readers.

"If anyone has problems we can help with, we'll figure out a way to get them looked at," said Dewey Price, branch chief for

HMOs with the U.S. Health Care Financing Administration.

Price said readers could call the agency's Atlanta office at 404-331-2549.

The newspaper has been flooded with calls in response to the HMO series, from people both inside and outside the state.

More than 700 calls had called by Tuesday afternoon.

Many readers said they were surprised to learn that the HMOs

Patients: Grievance system a quagmire

■ Fourth in a series.

by LARRY KELLER
and ROBERT SCHULTE

Michelle Stratton's father died beside her in the front seat of her car outside a Medicare HMO clinic in Tallahassee, Fla., she says. If the health maintenance organization had hospitalized him for a heart ailment hours before he died, Stratton says, still fighting to avenge her father's death.

"I'm 26 years of age," said Stratton, a TV news anchor, KTVX-TV in Salt Lake City, Utah. "Stratton has learned a bitter lesson about the state's health care laws and the regulators paid to uphold them often side with the HMO industry — not with patients who are wronged."

Her case fits a trend seen by the *Sun-Sentinel* in a six-month review of the elderly health care system and hundreds of grievance appeals and other HMO disputes.

Among the problems:

- HMO patient disputes take, on average, four to five months to settle. Many people get impatient for an adequate hearing, or are burned under paperwork and arbitrary practices.
- HMOs' appeal rules give HMOs considerable leeway to deny payment for bills members incur.
- State law forbids adults from collecting damages for the wrongful death of a parent, which limits lawsuits against Medicare HMOs even if they are negligent.
- "When I started, I hit so many red lights," Stratton said. "It's terrible. I don't think the system works for the big power players."

Stratton was at work in Utah in October, 1990, when her mother phoned from South Florida to say her father, Joseph Friedman, was seriously ill. She flew to Florida the next day and learned her father had been denied admission to a hospital.

"He looked like he had just gotten out of Auschwitz," she said of her once-robust father. "He was yellow and emaciated."

Early the next morning, Friedman, 69, began sweating and vomiting. "He had major [swelling] in his ankles," Stratton said. "Paramedics took Friedman to Humana Hospital, Dade County, which declined to admit him."

Stratton's father was a Medicare Gold Plus primary care physician, Dr. Martin Treiber. "Humana executive Joe Berding said the hospital should have paid the HMO for the treatment for services to members whose physicians cannot be contacted within 30 minutes."

Treiber was told to keep his appointment to see Stratton a few hours later. Stratton drove him. When they arrived, Friedman looked worse. "I pressed that button and saw inside Treiber's office for help."

The doctor came out, listened to Friedman's heart, with his hand on his forehead, and then died. "Treiber walked back to his office without another word, according to Stratton. Friedman had died of a heart attack."

Stratton returned to Utah and her mother, Grace Friedman, came to live with her. They sued Humana, Treiber and three Humana doctors. The suit was filed in a state court, but the state agency now physicians for medical negligence.

Stratton also demanded a hearing before Humana's internal appeals board. "I was told that the first stage patients must go through to press a complaint of poor quality care."

care of his patients, records show, according to exacting standards. Stratton says Humana's medical licenses revoked, and Humana does not have authority to do that, he said.

Stratton was satisfied. She filed a complaint with the Florida Agency for Health Care Administration, which investigates HMO medical quality complaints. "My complaint was never resolved," she says. "Florida HMOs pay no penalty for violating state quality standards."

a *Sun-Sentinel* analysis of agency complaints about HMO care. Of 300 medical quality complaints filed against Humana between January 1991 to September of this year, the company was fined \$5,340 in only three of the cases.

In Stratton's case, the agency conducted an audit that found no fault. "Humana did not ignore the severity of her father's illness," the hospital did not take appropriate action per its policy and procedure, the agency without another word, according to Stratton. Friedman had died of a heart attack."

That finding encouraged Stratton that the Florida Department of Business and Professional Regulation and the emergency room physicians from practicing medicine. But the agency told Stratton in September, 1992, and in January 1993, that the agency would not prosecute two of the doctors because of insufficient evidence.

A year and a half later, Stratton sued the two doctors and other two doctors. One of them, Treiber, has since died.

Frustrated by state inaction, Stratton turned in September

Reader views

HMO members and their families who write to the *Sun-Sentinel* rarely used patient grievance procedures set up by HMOs or state and federal government agencies.

PRO

Most happy HMO members thought the HMOs had failed to follow the HMO's rules, or were hard to please. "We will receive many complaints about HMO care. Old people with many ailments always feel they are neglected." — Margaret Handington, Coral Springs, Fla. Source: *University of South Florida*, March 1993.

CON
Only five of 172 writers who wrote to the Florida Department of Insurance "in all the complaints I put in [with the HMO] only once did I receive an answer in which a problem was found and action was taken to resolve it." — Barbara Brown, Boca Raton, Fla. Source: *University of South Florida*, March 1993.

checking on quality," admitted one U.S. Health Care Financing Administration official.

The agency has never required HMOs to provide hospital use data and other standard medical quality statistics to the state. The agency said officials compare the performance of HMOs to the performance of HMOs require that Medicare enrollees seek emergency care, but they also allow HMOs to refuse payment if they think the ailment did not need emergency treatment.

Humana HMO members who seek emergency treatment for severe pain that turns out to be caused by a minor ailment are not paid for the care, the HMO refused to pay the bill.

Stratton learned Medicare appeals often seem to take forever. "I've been waiting for the health-care agency passed her complaint on to the peer review organization paid to study quality complaints. A year later, she is still waiting."

Dr. Robert A. Turkel, medical director of the peer review group, conceded that the process is slow. "The process is intended to make sure doctors are not wrongly accused."

Stratton feels she suffered the ultimate injustice when she tried to sue Humana. "I was told to sue the state, but the state said she filed with her mother."

She was an invalid who had been in a nursing home for her husband, according to Stratton. Stricken with cancer in her dam, Grace Friedman battled a number of other ailments, in-

cluding emphysema and heart problems. Stratton said.

Grace Friedman "just wanted to die," Stratton said.

She did die. Humana and the doctors were no longer liable because, under a little-known Florida law, the only medical malpractice cases are those who are minors, defined by the state as people under age 25.

"I'd be willing to bet good money that if the state didn't have that law because it was put in through the political muscle of the medical industry in Tallahassee," said Humana personal injury lawyer, Leonard Friedman.

Every life ought to have a value," said Dick Langley, a former Humana lawyer. "The state of Florida sponsored one of the bills. It's just arbitrary to say you're over 25 so your parent's life has no value. People die over the death of a spouse, the odds were stacked against Stratton's mother."

Malpractice defense attorneys often stall these lawsuits, hoping to wear down the plaintiff. In the case as settled, said Donald Toblin, a Fort Lauderdale doctor-turned-lawyer who now sues his former colleagues, "the defense lawyers can save their HMO clients millions of dollars in judgments."

Statistics show that one elderly spouse dies, the other often follows. "If that happens, the HMOs will pay nothing. Under Florida law, nobody else is eligible to recover damages," Toblin said. "That's a trick for them."

State officials promise action

Legislators, administrators say they will attack HMO problems



By LARRY KELLER
and FRED SCHULTE
Staff Writers

State legislators and officials on Wednesday vowed an immediate attack on HMO problems and other abuses disclosed by a *Sun-Sentinel* series on Florida's HMOs for the elderly.

"We're going to do a major rewrite of the HMO laws this year," said state Rep. Ben Graber, D-Coral Springs, a physician who is chairman of the House Health Care Committee. "I've heard for years that there are problems with HMOs."

Graber said he would draw on information disclosed by the newspaper articles in upcoming legislative hearings.

The five-part series, which concludes today, revealed that thousands of Medicare HMO patients in South Florida have alleged deficiencies ranging from negligent medical care to the loss of tens of millions of dollars in hospital and doctor bills.

More than 300,000 Florida seniors have given up standard Medicare for the HMO program, which charges them minimal or no premiums. Medicare HMOs are paid a set fee every month, about \$300 in South Florida, for the care of their members.

"I think your series has given us a very significant impetus, and we're grateful for it," said Doug Cook, head of the state's Agency for Health Care Administration in Tallahassee.

Cook said current laws regulating the state's 32 licensed HMOs

"There are a lot more people going into managed care. What Florida's going to have to do is make sure the consumer gets the quality of care they pay for."

— Sen. Howard Forman, D-Pembroke Pines



"We're going to do a major rewrite of the HMO laws this year. I've heard for a long time about problems with HMOs,"

— state Rep. Ben Graber, D-Coral Springs, House Health Care Committee chairman

have failed to weed out "unscrupulous" doctors who provide substandard medical services.

"We need to recognize there is a great deal of cleaning up we

a health care reform bill earlier this year, the time is ripe to demand more accountability from Florida's HMOs, Graber said.

"We have to amend the whole HMO statute. They've made the rules a little lax for them. We need to tighten it up," he said.

Graber said he is concerned HMOs dump members once they develop chronic and expensive illnesses. "You can't just disenroll people and throw them out, which is what some HMOs are doing," he said.

State Sen. Howard Forman, D-Pembroke Pines, also promised legislation to crack down on errant HMOs.

"I'm planning on plowing a lot of new ground here," said Forman, who is chairman of the Senate Health Care Committee.

"There are a lot more people going into managed care," Forman said. "What Florida's going to have to do is make sure the consumer gets the quality of care they pay for."

Finance Commissioner Tom Gallager, whose office oversees the finances of HMOs, also is concerned about abuses in some HMOs, said spokeswoman Jill Chamberlin.

"Managed care in Gallager's opinion is the future of medicine in terms of controlling costs," Chamberlin said. "But we agree there need to be improvements in their services."

The *Sun-Sentinel* series drew on thousands of pages of government files and computer data, court records and more than 350 letters from readers.

HMO SERIES FINDINGS

DAY 1

■ Thousands of people have complained to the government of HMO problems ranging from poor-quality medicine to failure to pay bills on behalf of HMO members.

■ Medicare HMOs very greatly in their access to physicians and hospital care, suggesting a trend some officials worry could signal improper rationing of medical care.

■ The HMOs are plagued by waves of disenrollment, in some cases, twice as many people quit the health plans as join.

DAY 2

■ Rapid disenrollments, a key indicator of abusive sales activities, are three times as fast as the national average in several area HMOs.

■ HMO financial disputes, including refusal to pay more than \$14 million in medical bills, have more than doubled since 1989 and are continuing to grow.

■ Cash bonuses paid to HMO doctors for holding down costs have raised ethical questions within the health-care industry.

DAY 3

■ HMOs often add hundreds of new doctors each year, making it difficult to check credentials properly.

■ Humana Medical Plans has terminated 50 physicians for poor performance, and most joined other area HMOs.

■ South Florida's competitive health care market, in which HMOs court doctors and let them share in profits, tends to undermine HMO quality-assurance efforts.

DAY 4

■ HMO patient grievances take months to settle and many people feel as if they never get an adequate hearing.

■ An obscure state law forbids adults from suing for the wrongful death of a parent. Critics think the law insulates Medicare HMOs from having to pay damages should they be negligent.

■ Many key records that could help consumers judge the quality of competing Medicare HMOs are kept confidential.

DAY 5

■ Florida's Health Services HMO remains in good standing despite accusations that it kicked out members who got sick and that it filed phony financial reports to deceive state regulators.

■ Tiny Clinica feds, partly owned by the family of a Miami state representative, has jumped along for years despite repeated financial problems and plummeting membership.

■ HMOs in South Florida are taking advantage of weak or unclear state laws to avoid paying members' medical bills.



HMO regulation proves a struggle

■ Last in a series.

By FRED SCHULTE
and LARRY KELLER

Staff Writers

Lourdes Health Services HMO has improperly kicked out members who got sick, refused to pay patients' medical bills and been implicated in a scheme to deceive state regulators, records show.

Yet the troubled Miami health maintenance organization expects to grow rapidly this summer.

Changed its name to Advantage Health Plans, expects a good deal of its expansion to come from a new line of business: the Medicare HMO program.

"That's very much the plan," said Ralph Egues Jr., Advantage's director of operations. "In recent years not only shows the ways HMOs can go awry for patients, it also raises doubts about the Florida insurance department's ability to investigate alleged violations of state standards."

The Sun-Sentinel found:

■ At least 39 Lourdes members complained since January that they had been kicked out of the HMO or denied benefits improperly. Some alleged they were expelled after the HMO learned they had expensive conditions, from pregnancy to terminal cancer. State law forbids an HMO from kicking out paying members who get sick.

■ State regulators advised the state in February that two employees pocketed cash premiums paid to the Atlantic Plan, a Lourdes affiliate. The former employee also alleged that the plan submitted false financial statements to regulators to conceal debts.

■ Lourdes' three annual reports filed since 1990 reflect shaky finances, while more than 20 lawsuits filed in Dade Circuit Court since 1992 allege nonpayment of hundreds of thousands of dollars in medical claims.

Florida Insurance Commissioner John Delaney said last week his agency is deciding whether to approve the sale of Lourdes, which has about 30,000 members in Dade, Broward and Palm Beach counties.

"Once we're finished with that, we're not going to just walk away," Gallagher said. "There may have been some things done [at Lourdes] that were illegal."

Egues, of Advantage, declined to discuss matters under review by the department of insurance, but commented:

"We made management changes in the last three to four months to address some policies we weren't happy with."

Martha Portilla lay in a hospital dying of cancer when she got the bad news: Her HMO had kicked her out to avoid paying her bills — more than \$100,000 worth.

A few days after being diagnosed with cancer in 1991, the Miami resident received a certified letter from Lourdes informing her that the company was canceling her HMO contract in 30 days.

Portilla ran up about \$100,000 in medical bills at hospitals and medical facilities before she died in December 1991. Her husband, Vincent, is now saddled with the debt.

Lourdes says it canceled Portilla for "underwriting reasons." The action was legal and spelled out in her contract, the company contends.

Portilla's attorney, Luis Stabinski, disagrees. He maintains that an HMO can eliminate a member from its plan only for cause, and he says there was no such cause in Portilla's case.

"They'll cover you in good health," Stabinski said. "The moment you get sick, you're out of there."

HMOs for working-age people, such as Lourdes, can reject applications from people with medical conditions that are costly to treat.

But state law forbids an HMO to refuse to pay for medical care

Reader views

Sun-Sentinel readers offered many ideas for improving the Medicare HMO treatment system or navigating through it. Here are a few:

Howard Silver, Tamarac

Idea: Set up a toll-free compliant hotline, and conduct field audits of HMO centers.

Comment: "The government should have field investigators who go files at HMO centers, pick out ten or twelve and call the people to see how they like the system. Medicare people need somebody to protect their interests."

Susan Mayhew, Plantation

Idea: Form a panel to visit patients.

Comment: "If HMO programs are to be effective, I believe there must be a non-biased and independent oversight board created to monitor and physically check on patients to monitor their care and services."

Source: Letters from Sun-Sentinel readers, May-August 1993



Charlotte Teller, North Lauderdale

Idea: Require HMOs to provide resumes of doctors. Comment: "They say they check out the doctors' background, but they want you to take it on blind faith without any information! It's like a roulette wheel."

Arthur A. Benson, Margate

Idea: Pay for physician specialists yourself.

Comment: "When we find the [HMO] specialist history (and we do), we choose our own and pay for it out of our own pocket. Actually, in view of the immense savings by belonging to an HMO, we can easily afford it."

Source: Letters from Sun-Sentinel readers, May-August 1993

Staff Writer DONNIE LALLY/SEBERT

done just that have been mounting for the last month, more than 20 lawsuits alleging Lourdes breached contracts with sub-

to treat an illness that became apparent after the patient joined the HMO. Complaints that Lourdes has

"They'll cover you in good health. The moment you get sick, you're out of there."

— Luis Stabinski, attorney for Portilla family.

scribers were pending in Dade Circuit court.

One suit was filed by a Dade man who spent 15 days in the hospital recuperating from a heart attack only to find that Lourdes had kicked him out of the HMO and was refusing to pay his bills.

The man had been a Lourdes member for 15 years.

State officials have yet to resolve allegations made in February against a Lourdes affiliate called Atlantic Plan. The accuser is a former company controller, who said she was fired for refusing to falsify financial statements to regulators to conceal debts.

"I feel strongly that these practices should not be allowed to continue," the former employee wrote in a Feb. 25 letter to the chief of the insurance department's Miami office.

State regulators review the financial reports because HMOs facing cash shortfalls might be tempted to refuse or stall needed medical services to save money.

In her letter, the former employee stated that the health plan ignored or delayed paying bills for as long as five months — unless the creditor complained to the insurance department.

State regulations require HMOs to pay claims within 30 days. State officials had warned Lourdes in January 1991 to begin keeping records showing claims were paid when due.

"Over the past several months, additional disturbing trends have become routine," the employee wrote.

Among her accusations:

■ As many as 200 people per month were kicked out after the health plan deliberately failed to deposit their premium checks. The intent was to charge the members a "reinstatement fee." As much as \$11,000 a month in fees was collected.

■ Members who got sick were accused of falsifying their applications to conceal pre-existing health problems.

■ The plan's doctors routinely delayed referrals to physician specialists and often refused to pay the bills, even when the health plan had authorized the treatment.

Perhaps most serious, the controller alleged that two executives "diverted to their own pockets" cash premiums paid by members each month.

Gallagher would not say what action had been taken to investigate the complaint.

"I can't discuss the case in public," Gallagher said. "Our investigation is continuing into the [HMO's] business practices."

Asked about the former employee's accusations, Advantage official Egues declined to comment.

Advantage Health Plans, formerly Lourdes, has signed an agreement to be sold to PacificCare Health Systems Inc., a California-based HMO that has more than 1 million members in five states.

The HMO is owned by Juan Barreiro, the uncle of state Rep. Bruno Barreiro Jr., R-Miami.

The sale must be approved by Florida's insurance department. If approved, the HMO, which now treats primarily working people and the poor, expects to apply for a Medicare contract as early as next year, Advantage executive Egues said.

State insurance officials also said they are concerned that a member of the Advantage staff has past involvement with a failed HMO.

The Advantage plan's director of commercial accounts is the brother of International Medical Centers founder Miguel Recarey, who fled the country after his indictment in 1987 on fraud and bribery charges.

Miguel Recarey, who was arrested last month in Spain, is fighting extradition to the United States.

The brother, Raul Recarey, changed his name to Raul Vieta in August 1992, Dade Circuit Court records show.

Vieta owned several International Medical Centers clinics. The centers became affiliates of Humana Medical Plans when Humana purchased the failed HMO in late 1987.

Vieta sold his Humana centers in 1991. He did not respond to numerous requests for comment.

But Egues of Advantage defended Vieta in a letter to the *Sun-Sentinel*.

"We do not discriminate in hiring based on an applicant's family, and consider it unjust to hold Mr. Vieta in any way responsible for actions by his brother," Egues wrote.

Insurance Commissioner Gallagher also declined to comment on Vieta's role in Advantage plans. In the past, however, department officials have disapproved of former IMC officials' holding management jobs in Florida HMOs.

Stop pushing seniors into HMOs

■ First of two parts.
Hundreds of thousands of senior citizens in Florida rely on Medicare HMOs for their health care — and trust that the federal government is doing everything it can to monitor quality and ensure high standards.

They should think again. A *Sun-Sentinel* investigative series found that government promises to rid Florida's growing \$1.3-billion-a-year Medicare HMO industry of quality problems, service delays and enrollment fraud remain unfulfilled.

Instead of cracking down on abuses by some Medicare health maintenance organizations and examining the reasons that large numbers of people are quitting the plans, federal officials have stamped ahead with the program, heralding it as the best way to deliver low-cost health care to seniors.

While many senior citizens are happy with their HMOs, the newspaper found that more than 10,800 complaints have been lodged against South Florida Medicare HMOs since 1987. The complaints ranged from restricting access to medical care to refusing to pay medical bills to fraudulent sales tactics.

At least 140 people blamed a loved one's death, injury or prolonged

suffering on HMO cost-cutting practices, the newspaper found.

The *Sun-Sentinel* first uncovered some of these flaws in a 1990 series about Humana's Gold Plus Plan HMO. Congress ordered audits and held hearings and some HMO quality regulations were tightened. Humana also made improvements and stepped up surveillance of contract physicians.

But the government has done little else to root out the causes of the industry's problems or to crack down on HMOs that improperly deny care, fail to pay bills or offer poor-quality medicine.

Some Medicare HMOs do a decent job policing themselves. Others do not, and they have been getting away with it.

This simply isn't acceptable. The government has a responsibility to create tough regulations — and enforce them. It has failed to do its job.

The series found, for example, that Medicare HMOs vary greatly in their access to physicians and hospital care — a disturbing trend that could signal improper rationing of medical services. Yet the government has never examined this variance or tried to determine its cause.

Nor has the government studied why seven South Florida HMOs are plagued by disenrollment rates that exceed the national average.

Nor have officials cracked down on Medicare HMOs that use exploitative enrollment tactics. Some elderly members end up beset by bill collectors after receiving care outside the plan because they didn't understand how Medicare HMOs worked or didn't even comprehend they had signed up.

In recent years, Medicare has paid at least \$5.7 million in claims — many stemming from enrollment abuses or improper denial of bills — that should have been paid by HMOs. Taxpayers shouldn't have had to pay a single penny.

One of the biggest flaws may be with the capitation system itself, in which Medicare pays the HMO a fixed fee each month per patient. In South Florida, it is about \$500. Many HMOs keep part of the payment and distribute the rest to the health plan's affiliated doctors.

The problem arises when an HMO decides to withhold care or fails to refer patients to specialists because the money will come out of its pocket. In essence, these HMOs are cost-cutting at patients' expense.

Some HMO doctors even get cash bonuses to hold down costs or have a share of their capitation withheld by the HMO as an inducement to cut costs or stay within a budget.

Either way, this is a disturbing trend that raises troubling ethical questions.

If less care means more money, then what is to stop doctors from withholding needed treatment?

Federal officials should take the lead and mandate tough penalties for any HMO or physician who delays or denies care to save money.

The government also should come down hard on any HMO that hires a doctor who has been kicked out of another HMO because of substandard performance.

Federal officials must act to correct these problems, not just give them lip service. Congress too, must see to it real changes are made, rather than holding hearings and issuing reports that do little but collect dust.

In theory, Medicare HMOs should be a good deal for patients who pay no premiums and get their medical care, prescription drugs, eyeglasses and hearing aids for free.

But, in practice, the program has serious flaws. The Clinton administration should stop urging seniors to join Medicare HMOs until the problems are fixed. HMOs that deny access to specialists and hospitals, fail to pay bills or offer poor-quality medical care should be slapped with a moratorium on new enrollments until they clean up their act.

Elderly people should no longer be casualties of a system that sometimes places profits over patients

Tougher state scrutiny of HMOs needed

■ Second of two parts.
Several Florida agencies have been entrusted with overseeing the financial, quality and treatment standards of state-licensed HMOs that care for the elderly and working people.

Not one of those agencies has been doing a good job.

This was one of the most disturbing findings in a *Sun-Sentinel* investigative series that uncovered serious flaws in the Medicare HMO system in Florida.

Whether it is because of bureaucratic inertia or a fear of bucking the medical establishment, state agencies have shied away from taking on a consumer-oriented role.

The Florida Department of Insurance, which is supposed to handle consumer complaints, monitor a company's financial stability and hear grievances, either is unable or unwilling to investigate alleged violations of state standards.

The Florida Agency for Health Care Administration, which is supposed to investigate HMO quality of care complaints, has never even examined the annual reports it receives about

unusual patient deaths, injuries and other problems, let alone acted to improve patient care.

The Florida Department of Business and Professional Regulation, which investigates complaints against physicians, has done nothing to identify which bad doctors move from one HMO to another or to revoke the licenses of doctors who delay or deny care to save money.

In short, the state agencies that patients rely on to monitor HMOs have failed miserably.

As an example, the newspaper revealed that the state Insurance department hadn't resolved 8-month-old allegations that a Miami-based HMO improperly kicked out members who got sick, refused to pay patients' medical bills and was implicated in a scheme to deceive state regulators. The state this week addressed some of the concerns after repeated inquiries by the *Sun-Sentinel*.

The department also dragged its feet in disciplining another Miami-based HMO with anemic finances and repeated violations of state standards. That HMO is partly owned by the father of a

state representative.

Insurance department officials apparently don't understand that they have an important role in ensuring that HMOs

provide a high standard of care. The agency is responsible for monitoring hospital and physician utilization rates, pending malpractice cases and grievances, yet it pays little attention to these duties.

That's a mistake. When an HMO has serious financial problems, it can directly affect patient care. The HMO's financial picture is closely tied to its services.

The insurance department must redefine its role and be prepared to handle quality problems, rather than just pass them along to the health care agency.

Equally important, legislators need to remove the web of secrecy that surrounds the HMO monitoring system. Patients are unable to get even basic information about an HMO's problems or its medical quality because of confidentiality laws.

Patients cannot see the annual death and injury reports HMOs file with the state health care agency because these are confidential under state law.

So, too, are the reports submitted by HMOs to the Department of Business and Professional Regulation listing doctors who are responsible for serious treatment blunders. These reports cannot be made public, whether or not any action is taken against the doctor.

By contrast, many files involving private practice doctors who face disciplinary actions are available for public viewing.

Federal quality regulations also are shrouded in secrecy. They forbid a medical-review group — the only panel that looks into HMO medical quality complaints — from even discussing its findings, let alone sharing them with patients.

Why shouldn't patients be able to learn everything they can about an HMO and its doctors? They are consumers paying for a service and they have a right to know about the quality of medical care provided by every HMO.

Legislators owe it to their constituents to insist that HMOs undergo tougher scrutiny and to repeal confidentiality laws so the sun can shine into the HMO industry.

Officials order HMO to stop signing up new members

By LARRY KELLER
Sun Staff

State officials have ordered Advantage Health Plan HMO to stop enrolling new members, saying the company's problems could result in "irreparable financial and physical injury," as well as potential loss of life.

The problems plaguing the Miami HMO — until recently named Lourdes Health Services — were detailed in the *Sun-Sentinel* on Thursday, the final day of a five-part series on HMOs.

Health maintenance organizations are medical plans that require members to use a particular set of doctors and hospitals. In exchange, members pay a fixed premium, typically lower than for traditional medical plans.

Dorens of Advantage members have complained that they were kicked out of the health plan after they became ill, and more than 20 others have sued for hundreds of thousands of dollars in unpaid medical bills, the *Sun-Sentinel* reported on Thursday.

Now a joint investigation of Advantage by the Florida Department of Insurance and the Agency for Health Care Administration has concluded that Advantage is seriously short of money and is not providing good care.

"We have found them to have significant problems on nearly a hundred issues," said Doug Cook, head of the state's Agency for Health Care Administration, which monitors HMO quality problems.

Advantage officials say they have made progress on the problems, but state regulators say otherwise. "We have improved the services to [members] markedly," said Ralph Egues Jr., Advantage's director of operations. "Clearly, the job is not finished."

State regulators placed the moratorium on Advantage's enrollment at 5 p.m. Wednesday. They said the HMO had not complied with a July 2 consent order aimed at improving the company's performance.

The state's action is considered severe and unusual in the HMO industry. "This has not been common up to this point," said Tom

"We have found them [Advantage] to have significant problems on nearly a score of issues."

— Doug Cook, director
Agency for Health Care Administration



Arnold, chief of health facility regulation for the Health Care Administration. Advantage has about 30,000 members in Dade, Broward and Palm Beach counties.

Among the quality problems Arnold said regulators found at Advantage:

- No governing board is aware of all facets of the HMO's operations, so internal monitoring is difficult.
- Advantage lacks procedures to handle grievances from members who have complaints about their care or their bills.
- The HMO's patient records are badly disorganized.

Under the July order, Advantage was required to settle 90 percent of its July claims in a timely manner, and 95 percent of claims for each of the next three months. Under state law, HMO claims must be paid in 30 days.

Regulators reviewed 1,310 medical claims filed with Advantage in July. Advantage did not pay quickly enough in 41 percent of the cases. And only 9 percent of the company's 165 Medicaid claims were paid promptly, according to state officials. No data were available for other months.

Nor did Advantage get an independent audit of the total number of unpaid medical bills pending, as required by the July order.

Also singled out for criticism by the Department of Insurance was Advantage's hiring in June of Raul Vieta at \$5,000 a month — \$6,000 a year.

Vieta is director of Advantage's commercial sales, which can include companies and government agencies.

He is the brother of Miguel Recarey, founder of the international Medical Centers HMO, which

was taken over by the state in 1987. Recarey fled the country after his indictment that year on fraud and bribery charges. Recarey was arrested in Spain last month and is fighting extradition to the United States.

Corporate records list Vieta's address as a Star Island mansion across the road from singer Gloria Estefan's home. Vieta could not be reached despite telephone messages and faxes seeking comment.

California-based PacificCare Health Systems Inc. has been negotiating to buy Advantage. PacificCare officials said the enrollment moratorium will not deter their efforts to buy Advantage.

They were very interested in the Florida HMOs in the past, said Lipeles, PacificCare's executive vice president.

Meanwhile, regulators from the two state agencies that stepped Advantage vow to conduct investigations of other Florida HMOs in the future.

"Frankly, we're going to be looking at a lot of other folks as well," Cook said.

Chairman STARK. The articles point out that over 10,000 complaints from Medicare beneficiaries have been filed against HMOs. This isn't just called into an 800 number—but our beneficiaries have gone through the difficult process of filing a formal complaint, 10,000, and many dramatically portray the appalling ways in which HMOs deny needed health care services simply to increase their profits. For example, when paramedics brought one Medicare beneficiary to Humana Hospital in Biscayne, Florida, he was refused admission and told to see his Humana Gold Plus primary care physician. By the time his family drove him to the doctor's office, he was dead of a heart attack.

Other beneficiaries have spent years fighting with HMOs which refuse to pay for emergency care provided when beneficiaries are out of town. Humana has even sued its own doctors for spending too much on patient care. These practices have no place in America's health care system.

Several of our witnesses today will discuss the experience of low-income populations and managed care. In theory, managed care plans offer the possibility of better quality care for the low-income population if they emphasize preventive services and provide true case management to help steer patients through the system.

But the reality we have seen in California and other parts of the country does not support this ideal. Most disturbing is that managed-care plans are all too often eager to enroll low-income individuals but fall far short when it comes to actually delivering the services they need.

For example, in recent weeks we have been hearing and reading about TennCare, a Medicaid managed-care program now underway in Tennessee with the blessing of the Secretary of Health and Human Services, although I haven't heard the blessing from prospective Senator Cooper on this plan. He remains strangely silent.

This State's attempt to force Medicaid enrollees into managed-care plans in a short period of time is fraught with problems. One mother says her 7-week-old baby died after she couldn't find a doctor willing to accept TennCare because there was none signed up in her particular county.

We have a number of expert witnesses with us today, and I look forward to their testimony to help us explore these and other issues related to managed care.

Before proceeding, I would recognize our Ranking Member, Mr. Thomas.

Mr. THOMAS. Thank you, Mr. Chairman. I, too, am pleased that we are having a hearing on managed care.

As Americans in the health care industry pursue the proper mix of cost reduction, choice and quality through new structures, the last thing I think we should do is attempt to legislate by anecdote. Tearing down one approach by anecdotal example to promote another is subject to the same attack, and I suppose I could go on about a number of horror stories in Medicare or other structures. That I hope is not our purpose.

What I am hoping for is a hearing covering hard data, and solid methodology to explain, if all that you have said is absolutely and usually true about this concept called managed care, why do more and more Americans agree to go under the program and why do

more and more studies show that it is at least one reasonable option among several others?

And I look forward to the testimony shedding some light on other than anecdotal examples, attempting to tear down rather than examine or explore.

Thank you, Mr. Chairman.

Chairman STARK. Are there any other Members?

Mr. Shaw, I took your name in vain.

Mr. SHAW. All right. I appreciate that, Mr. Chairman, and I very much appreciate your calling this hearing.

There are a lot of flaws in HMOs, and I can certainly associate myself with your statement, although I think you and I may be going in different directions to the ultimate solution. I think to take a real closeup look at this particular option is extremely important. HMOs do present a whole myriad of problems that are new to the health care delivery system, and I think it is very incumbent on this committee particularly to take a very, very close look at it as part of the overall hearing process going toward some type of health reform. And I thank you very much.

Chairman STARK. If the gentleman will yield, I concur.

There are arguably managed care and HMOs that provide excellent care for large numbers of people. It is the fact that we have precious little experience in the regulation or learning how to evaluate them in setting financial standards, and what we had hoped today to hear from our witnesses is the types of things we ought to be concerned about prospectively to regulate those situations or to insure that our beneficiaries get the care they pay for. And I think that is the real issue.

I appreciate the gentleman—

Mr. SHAW. I think you very clearly made reference to this in your statement.

Part of the goal of many of the HMOs is to keep the primary physicians, to keep the patient away from the specialists, and that is the worst kind of rationing you can possibly have. So I think it is very important that you have this hearing, and I think it is very important that every once in a while we continue to have these hearings.

And I thank you very much.

Chairman STARK. Thank you for joining us.

If there are no further statements, I would ask that our first witnesses, who are well known to the subcommittee and to the health care community in general—Dr. Philip R. Lee is the Assistant Secretary for Health in the Department of Health and Human Services, and Dr. Bruce Vladeck is the Administrator of the Health Care Financing Administration, affectionately known as HCFA.

They will present the administration's perspective on the role of managed care in health reform, and, as with other witnesses today, the written statements will without objection be made a part of the record. And I would encourage the witnesses to expand on their testimony or summarize it in any manner that they are comfortable.

Chairman STARK. Phil, do you want to lead off?

STATEMENT OF THE HONORABLE PHILIP R. LEE, M.D., ASSISTANT SECRETARY FOR HEALTH, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. LEE. Mr. Chairman, thank you very much. Dr. Vladeck and I are delighted to join you with somewhat different hats on today than has been the case in years past.

Let me begin with a brief discussion of managed care generically. Managed care has meant many things to many people, and today managed care is characterized by several things: first, arrangements with selected providers to furnish a comprehensive set of services; second, explicit standards for participating health providers; third, formal programs of quality assurance and utilization review; and, fourth, incentives for enrollees to use plan providers. Some plans also include provider assumption of some financial risk and integration of medical facilities.

Within this broad framework, many new organizational structures have developed over the last decade. Some, of course, developed many years before that: Health Maintenance Organizations, Independent Practice Associations, Preferred Provider Organizations, Point of Service Plans, service specific case management—for example, a managed-care prescription drug benefit or a mental health managed-care benefit and high-cost case management programs, for example, for heart transplants.

They are fairly distinct structures, these different arrangements, and they are still evolving. The early IPAs, for example, were little more than loose confederations of fee-for-service providers with little quality review, which have evolved significantly in recent years.

Growth in managed care, as you point out, Mr. Chairman, has been significant, particularly in recent years, partly stimulated by the 1973 HMO act. In the rush to develop HMOs after that, significant problems emerged, and I think we learned a number of lessons from those experiences and have since, I think, improved both the oversight and within those plans made significant improvements in terms of quality management.

Today, programs recognize—managed-care programs—that cost control requires a commitment to better health care outcomes and continuous quality improvement. Indeed, Dr. David Lawrence, who is the CEO of the Kaiser Hospitals and Kaiser Health Plan, has said to me that their reductions in the rate of increase in costs in recent years is related almost entirely to their continuous quality improvement program which they initiated about 5 years ago.

The objectives can best be met through integration of services and continuous monitoring of quality, as well as the service aspects of caring for subscribers.

Although we know less about some of the recent managed-care organizational forms, such as Preferred Provider Organizations and point-of-service options, health services research since 1980, comparing managed-care programs to indemnity or fee-for-service plans, demonstrates the capacity of managed care to improve the delivery of health care in the United States.

Compared to indemnity plans, managed-care plans appear to achieve the following—I note these on page 5 of the testimony: Lower hospital utilization; greater use of less costly alternatives to expensive procedures or tests; greater use of preventive examina-

tions, procedures and tests with equivalent use of primary care visits for enrollees; comparable quality of care; comparable patient satisfaction—although the satisfaction is greater on the cost side than on things like waiting time in the office; and lower cost increases.

The Medicare TEFRA evaluation estimated 11 percent lower total expenditures per enrollee, reduced hospital costs in markets with high managed-care penetration, and premium rate of growth which, since 1988, appears to have been slower, particularly according to a recent Group Health Association of America report where they have reported that the premium increases in managed-care plans were 4 to 6 percent below that of indemnity plans between 1988 and 1992.

So there are potential significant cost savings. There are also potentials for the improvement in the quality of care. The goal is to contain costs through better integration of care and continuous quality improvement. It is not to regulate providers through clinically intrusive and uncertain utilization review.

Leading managed-care plans recognize that improving integration and focusing on quality of care are the keys to real cost control and better health for our communities.

The administration shares this committee's concern regarding the potential of underservice or inappropriate service in both managed-care plans and in fee-for-service plans. To guard against potential problems, the Health Security Act requires plans to be responsible for meeting the health care needs of a defined population of patients and restructures the insurance market to minimize risk selection.

One of the most important aspects of the President's proposal for health care reform is the way it restructures both personal health services and public health systems, and in this I think it is unique in the plans that have been presented thus far to the Congress. This restructuring will increase our ability to improve the health of the public and reduce disparities in health status.

Key characteristics of the Health Security Act that enlist the personal health care system in achieving public health objectives include: Universal coverage; comprehensive benefits, including clinical preventive services without deductibles or copayments; a new focus on populations—the alliance and the health plans are responsible for making sure that their populations have access to covered services, and a national system of performance monitoring focuses the attention of health plans on achieving healthy outcomes for their enrollees; financing and payment systems that reward plans for keeping their populations well; and—extremely important—an information system that links enrollment and encounter information that can detect underservice by plans.

With a reformed private delivery system, public health can focus on removing barriers to care for low-income, isolated, excluded and chronically ill populations through the Health Security Act's access initiatives.

These are detailed in Title III of the Health Security Act, and I won't detail them for you now, but they do include: Strengthening the current safety-net programs and integrating them with private health plans through the development of practice networks; in-

creasing the supply of providers in underserved areas—by expanding the National Health Service Corps, for example; expanding capacity in the inner-city and rural areas; providing additional support for outreach and enabling services; support for comprehensive education and health services for school-age children and adolescents; support for community-based prevention programs and core public health functions; and expanded access to mental health and substance abuse treatment services.

Included also in the Health Security Act are significant measures for consumer protection and quality assurance. And let me just cite the quality assurance provisions:

First, national quality measures which will be established by the National Board.

Plans will be required to publish annual quality report cards that will allow consumers to compare the performance of each health plan within their alliance and choose their health plan based on these uniform quality measures and premium costs.

I would say that recently the Kaiser Health Plan in northern California, the Kaiser Permanente, has published what is a pioneering report card which I think would merit careful attention because it does represent the first major effort to produce a document for consumers, and we will see much more of this. And part of the plan's intention is to make those available so that consumers can choose among plans based on quality.

The Agency for Health Care Policy and Research will expand outcomes research and increase the development of clinical practice guidelines.

Regional professional foundations composed of academic health centers, schools of public health, plans and providers will be at the center of continuing education of health professionals and disseminate information to those who need it.

States will establish quality criteria and certify health plans based on the criteria.

And administrative simplification will reduce paperwork for providers and allow more time for continuous quality improvement.

Enrollees have the right to change plans annually or seek services outside their plans under the point-of-service provisions.

In my testimony I also describe briefly the improvements that will be possible in access to care in rural areas under the Health Security Act. Similar efforts will be made to provide and improve access to underserved inner-city areas because having a health security card does not assure access unless physicians and other providers are available.

In summary, the Health Security Act supports continued improvement in the way we organize and deliver health care services, especially services for the most vulnerable populations, those with low-income, children and adolescents and the excluded members of our communities.

Dr. Bruce Vladeck will now discuss how managed care has been introduced into Medicaid and Medicare and relate what we have learned about consumer protection in appraising the quality of care.

Thank you.

Chairman STARK. Thank you.

STATEMENT OF THE HONORABLE BRUCE C. VLADECK, ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Chairman STARK. Bruce.

Mr. VLADECK. Mr. Chairman, members of the subcommittee, it is a pleasure to be back with you this morning, and it is a particular pleasure and honor to share the witness role this morning with my colleague and friend and mentor and in some ways role model, Dr. Lee.

I have been assigned the role of talking primarily about the Medicare and Medicaid programs and HCFA's responsibilities relative to managed care in Medicare and Medicaid, although we are also responsible, as you know, for administration of what is left of the Federal HMO Act in terms of federally qualified HMOs. But I want to talk about Medicare and Medicaid today.

As you know, for two decades those programs have been using managed care to serve some number of their beneficiaries. We are the world's largest purchaser as well as the world's largest regulator of managed-care services. At the moment, approximately 8 million Medicare and Medicaid beneficiaries are enrolled in managed-care plans of one sort or another.

I think that in the past there was a tendency on the part of many people, perhaps including those in the executive branch, among others, to view managed care as a kind of panacea, to uncritically promote managed care as the answer to all our problems of access and cost in the health care system.

I think three generations into these programs, our current initiatives and the specific provisions of the Health Security Act reflect what I would like to think of as a much more mature understanding and view of managed care, not only in terms of the issues associated with providing high-quality care to people of all kinds at affordable costs but in terms of the public responsibilities relative to managed-care plans.

We believe that under appropriate circumstances with appropriate oversight, managed-care plans do indeed provide beneficiaries in both the Medicaid and Medicare programs the opportunity to receive broader benefits and high-quality services and better access to services than have been possible for them in the fee-for-service system.

But that won't happen by itself, and there are many things we, as well as in cooperation with you, have to do in order to achieve the full potential of the expansion of managed care in the Medicare and Medicaid programs while assuring the best possible protection of our beneficiaries.

Let me elaborate just briefly. There is more, obviously, in the written statement we submitted.

We think that the right kind of managed-care arrangements hold special promise for State Medicaid programs and their beneficiaries because, to be blunt, in many parts of the country fee-for-service medicine simply has not adequately met the needs of large segments of the Medicaid population.

There are difficulties in finding access to appropriate care for Medicaid beneficiaries in many communities to some extent because providers are reluctant to serve beneficiaries, to perhaps a

greater extent because in communities in which there are particular concentrations of Medicaid beneficiaries there are serious shortages of providers, particularly primary-care providers.

There are also a whole host of cultural, linguistic and other barriers that stand between Medicaid beneficiaries and the fee-for-service system. Part of the result is an excessive reliance on emergency rooms and other episodic providers of care as primary sources of care for too many Medicaid beneficiaries.

It is more appropriate, higher quality of care, more satisfying for the individual as well as less expensive to get people into organized systems of care from which they receive access to a good primary-care provider as well as the full range of services.

I know that you are aware, Mr. Chairman, that the first generation of Medicaid managed care, beginning in the early 1970s as a response to the escalating costs of the Medicaid program, produced some particularly unhappy results, especially in California under the Reagan administration.

The early experience with excessive expansion in an age in which we didn't know very much about the characteristics of the plans or the things that could go wrong produced significant instances of plan skimming, of unscrupulous and, in many instances, illegal marketing methods, many instances of poor quality of care, and particular problems of plans that enrolled beneficiaries and then closed their doors to them because they became financially unstable or organizationally unstable.

That is two generations ago, though, in terms of the evolution of the governmental role relative to such plans.

By the 1980s we really were in a second generation with much more explicit Federal quality standards and a new set of relationships with the States. We began to develop an infrastructure of performance standards and reporting requirements to give us a handle on the monitoring of at least the structural characteristics of plans and an ability to track some of the people in them.

We are now, we think, moving into a third generation of our activity in terms of Medicaid managed care. We are moving ahead with a variety of different, more flexible models, managed care tailored to the needs of particular States and communities, and we are giving States more flexibility than ever before to design and manage their own programs.

We are beginning to explore a range of new payment methodologies going beyond the 95 percent of what the fee-for-service experience might be. And, in doing so, we are just responding to an enormous ground swell of interest and activity from the States.

At the moment, 45 States now enroll at least some Medicaid beneficiaries in managed-care plans, and all of the remaining States are planning to adopt some form of managed care for Medicaid populations in the near future.

In terms of our total population, about 15 percent of Medicaid beneficiaries nationally are now enrolled in managed-care plans. The major impact on that growth will be the plans in both California and New York to move up to half of their enrolled populations into managed care by the end of 1995.

We have seen, again, particularly in those instances where underserved populations have not had adequate access to primary

care services, not only a reasonable level of beneficiary satisfaction and a favorable cost experience from the managed-care plans, but actual measurable improvements in health outcome, particularly reductions in infant mortality.

Under our Alabama waiver program, infant mortality for women enrolled in that program has decreased from more than 14 per thousand births in 1988 to fewer than 12, with a concomitant reduction in neonatal intensive care days.

In South Carolina, a somewhat similar program produced a reduction in infant mortality rates from 13.2 deaths per thousand live births in 1986 to 11.6 in 1990, and we are beginning to track similar experiences elsewhere in the country.

Some of the better Medicaid managed care programs have been able to build into their systems special outreach for pregnant women, for teenagers, for young children. They are also able to use the flexibility inherent in a capitated system to provide the kinds of services, such as intensive case management, expanded environmental and social assessments, a provision of child care, and substance—expanded substance abuse treatment, that are very much needed by some of these populations and not always available in the fee-for-service sector.

But we need to move significantly further ahead with our ability and the State's ability to monitor the quality of services being provided to Medicaid beneficiaries in managed care.

Earlier—late last year—we issued guidelines for Medicaid managed-care programs, laying out our new quality assurance guidelines for the States. We have been fortunate that the Kaiser Family Foundation has supported an evaluation of the implementation of those guidelines in three States. We should have some results on that by the second quarter of next year.

We are also working with the National Committee on Quality Assurance and some of the private-sector leaders in managed-care quality monitoring to explore the adoption of some of their quality assurance techniques to Medicaid populations and Medicaid programs.

On the Medicare side, managed care is also growing. We now, again, have almost 3 million beneficiaries who have enrolled in the close to 200 plans with which we have contracts. In general, they do so because of the incentives associated with somewhat broader benefit packages and lower out-of-pocket costs than Medicare fee-for-service is able to offer.

All of the studies we have done or have seen—and I want to emphasize—show that, in general, the quality of care provided to Medicare beneficiaries by Medicare HMOs is as good as or better than care provided to comparable beneficiaries in the fee-for-service sector.

Similarly, our measures of patient satisfaction in the Medicare program, in the more limited studies we have done, are analogous to those in the private sector: greater satisfaction with out-of-pocket costs, with the extent of coverage, with the reduction in paperwork; less satisfaction with responsiveness at the point of contact with providers in some instances.

But, having said that, the important issue is that we know in both fee-for-service and managed care that there is considerable

variance from one plan to another, from one physician to another and from one community to another in both quality and cost-effectiveness, and that our technologies and methods for measuring and monitoring the quality of services in managed-care environments, just as in the fee-for-service sector, are antiquated and in need of considerable improvement.

We have to improve the techniques we use to measure quality in all settings in the Medicare program, and we are engaged in what we call the Medicare quality improvement initiative to help us do so.

We are working, in terms of HMOs particularly, through a contract with the Delmarva Foundation for Medical Care, to develop an entirely new performance measurement system that the peer review organizations can use to review the quality of care delivered to Medicare beneficiaries. We hope to have the measures and the instrument ready within the next several months and to begin pilot testing later this year.

As you know, there has been considerable discussion of the fact that our studies show that, because of inadequacies in our payment formula, Medicare is not adequately reaping the potential savings that should be available to it from the growth in enrollment of beneficiaries in managed-care plans.

In fact, the latest study by the Mathematica Policy Research Corporation, which has been so widely cited, showed that, in fact, all other things being equal, HMOs serve Medicare beneficiaries at a lower cost. But because of our pricing methodology and the problems of risk selection, we don't—the program does not—share in any of those savings. In fact, we end up paying more for beneficiaries after risk adjustment under our current methodology than we would if they had remained in the fee-for-service system. And there are inherent biases built into the voluntary enrollment process because beneficiaries with chronic health problems are more likely to have continuing relationships with a physician and, reasonably enough, are less likely to want to change physicians or to disturb their existing care arrangements.

Similarly, much of the growth in Medicare managed-care enrollment has come about from the aging in of folks who have been enrolled in HMOs before they retired and became eligible for Medicare. And as HMO penetration in the private sector increases, that phenomenon will increase. But, again, those folks are all early retirees and relatively healthier and younger among our Medicare beneficiaries on average.

So we need to do a substantial amount of work to improve our payment and risk-adjustment methodologies. We have talked about that before in front of this subcommittee.

We have a range of research and demonstration activities described in the submitted statement which I would be happy to answer any further questions about if you like.

Let me just conclude by saying a few words about the Health Security Act and some of the provisions there because they are consistent not only with the broader shape of the President's proposal for health care reform but with directions in which we think it is necessary to go with managed care—in the Medicare program, in any event.

We do need to get better control of the consumer information and education process, of the enrollment process and of the plan selection process. Therefore, the Health Security Act calls for an annual open enrollment period in which marketing to beneficiaries is done not by the plans themselves, but through a third-party intermediary contracting with us, to serve a function similar to what the alliances will serve the private sector, of having a neutral intermediary between individuals and plans to provide them with objective information about the benefits and costs associated with each of their possible choices.

We have to provide a level playing field in terms of that decision-making process between HMOs and medigap policies as well. Perhaps more importantly, we have to begin to develop for Medicare beneficiaries some other forms of managed-care opportunities that are increasingly available to folks in the private sector.

We are particularly eager to explore development and ask for authority in the Health Security Act to explore the development of Medicare point-of-service options, partially open, partially closed plans under which enrollees do not have to lock themselves into any particular set of providers but can receive a reduction in copayments or other benefits if they use particular providers with whom we have special contracts.

Given the volume of services which we purchase and what we know about the interrelationship between volume, quality and cost for certain services, such as coronary bypass grafts or other surgical procedures, it seems to us that both the beneficiaries and the program could benefit if we had an expanded process of contracting with preferred providers for identified services under the Medicare program.

In summary, when they work well, managed-care programs have demonstrated their ability to meet the special needs of both low-income individuals and the elderly as well as the privately insured working age population.

Our basic policy goal is to provide our beneficiaries with as many choices about arrangements for their health care as possible in the context where they have good, objective information about the quality of services, the economic implications and the service delivery characteristics of the plans from among which they are choosing.

We believe that such a range of choices is the heart of the President's approach in the Health Security Act and also consistent with developments in the private sector, and certainly beneficiaries in public programs deserve no less.

We made a significant investment in improving our ability to assure quality and cost savings through the use of managed care in the Medicare and Medicaid programs, but I would be the first to acknowledge that we have a long way to go in refinement of both our quality measurement and reimbursement tools, and we very much look forward to working with you in the months and years ahead as we seek to further improve these tools, the protections of the beneficiaries while controlling the costs of our program.

Thank you very much.

Chairman STARK. I want to thank you both.

[The prepared statement follows:]

TESTIMONY OF PHILIP R. LEE, M.D.
 ASSISTANT SECRETARY FOR HEALTH
 DEPARTMENT OF HEALTH AND HUMAN SERVICES
 AND
 BRUCE C. VLADECK, PH.D.
 ADMINISTRATOR
 HEALTH CARE FINANCING ADMINISTRATION

Mr. Chairman and members of the Subcommittee:

I welcome this opportunity to discuss managed care and health care reform. The increasing dominance of managed care plans in many parts of the country and the importance the Health Security Act places upon encouraging their development, raises questions about the success of managed care in serving low-income and culturally isolated communities, and I am pleased to address these questions with the Subcommittee.

Before I turn to specific issues regarding managed care, it is important to establish a common definition. The term "managed care" has been generically applied to many different organizational forms of integrated service delivery. The experiences of the various types of organizations differ, and it is important to distinguish among them in evaluating the success of managed care.

MANAGED CARE IN THE 1990'S

Changes in the current health care system are being led by providers and purchasers of care who are transforming the fragmented fee-for-service system into integrated delivery systems. These integrated delivery systems - providers, facilities, and administrative functions working in a coordinated fashion - focused on providing quality care are today's managed care programs.

Today, Managed care is characterized by:

- Arrangements with selected providers to furnish a comprehensive set of services;
- Explicit standards for participating health providers;
- Formal programs of quality assurance and utilization review;
- Incentives for enrollees to use plan providers;

Some plans also include:

- Provider assumption of some financial risk and
- Integration of medical facilities.

Within this broad framework, many new organizational structures have developed over the last decade. They include:

- Health Maintenance Organizations (HMOs);
- Independent Practice Associations (IPAs);
- Preferred Provider Organizations (PPOs);
- Point of Service plans (POS);
- Service specific case management (e.g., prescription drugs or mental health care carve outs);
- High cost case management programs (e.g., heart transplant capitated programs).

They are fairly distinct structures and each is still evolving. For example, early versions of IPAs were little more than a loose confederation of fee-for-service providers with little quality review. Today, because of innovations in quality assurance programs and better organizational integration, they provide care comparable HMOs.

GROWTH IN MANAGED CARE

The past 20 years has seen dramatic growth in both the number of managed care plans and the volume of enrollment. In 1992, more than 575 HMOs provided care to 42 million people, and about 1,000 PPO plans served an additional 85 million.

The growth of managed care began in the 1940s with the development of HMOs such as Kaiser Permanente and the Group Health Cooperative of Puget Sound, and continued slowly throughout the 1950s and 1960s. In 1973, passage of the HMO Act stimulated the growth of managed care, and numerous states rushed to implement programs with federal assistance. The rush and lack of preparation created problems for many plan enrollees. And some of those bad experiences have yet to be forgotten. However, they did teach us important lessons about how to set up health plans, how to run managed care programs that focus on quality of care and patient satisfaction, and how to serve all segments of the population with special needs.

As a result, today's experience for low-income populations in managed care is not that of the 70's. For example, OBRA 81 permitted the State of California to introduce selective contracting for hospital services and develop innovative public and private managed care programs. These efforts have made high quality hospital and physician services available to previously underserved MediCal populations throughout the state.

MANAGED CARE PERFORMANCE IMPROVEMENTS

Critics often fail to recognize the advancements that have revolutionized "managed care." Today, such programs recognize that cost control requires a commitment to better health outcomes and continuous quality improvement. These objectives can best be met through integration of services and continuous monitoring of technical quality as well as the service aspects of caring for subscribers.

Mixing the experience of the early years of managed care with today's fails to capture the progress that has been made in understanding how to assure quality and service while keeping costs under control. Although we know less about some of the most recent managed care organizational forms such as preferred provider organizations and point of service options, health services research since 1980 comparing managed care programs to indemnity (or fee-for-service) plans demonstrates the capacity of managed care to improve the delivery of health care in the United States.

Compared to indemnity plans, managed care plans appear to achieve:

- Lower hospital utilization;
 - hospital admission rates are lower, hospital lengths of stay are shorter by 0-20 percent;
- Greater use of less costly alternative to expensive procedures or tests;
- Greater use of preventive examinations, procedures, and tests;
 - primary care visits per enrollee are similar or higher;
- Comparable quality of care;
- Comparable patient satisfaction;
 - much greater satisfaction with out-of-pocket costs;
 - greater satisfaction with benefits;
 - satisfaction with patient-physician interaction;
- Lower cost increases;
 - Medicare TEFRA evaluation estimated 11 percent lower total expenditures per enrollee;
 - Reduced hospital costs in markets with high managed care penetration;
 - Premium rate of growth is slightly lower

POTENTIAL COST SAVINGS OF MANAGED CARE

If all Americans participated in managed care programs under the current system of incentives, the Congressional Budget Office recently estimated the potential savings in total health care expenditures range from 1 to 10 percent. With different incentives in place the effects could be larger. Over the last three years health care costs have not grown as sharply as in the previous decade. It is difficult to determine what continuation managed care has made to this slowing rate of growth. However, the recent figures may reflect the rapid adoption of managed care by employers and state governments. Furthermore, managed care plans exert downward pressure on premium increases.

Opinions differ regarding managed care and premium price increases. However, several examples suggest their potential benefit. For example, representing more than 875 state and local government employers and their families, Calpers, the California Public Employees Retirement System, has used its bargaining power to limit premium increases in 1992 to 3.1 percent compared to the state's industry average of 13.2 percent. Similarly, large and medium firms report decreased rates of premium increases with managed care.

THE HEALTH SECURITY ACT PROMOTES HIGH QUALITY CARE

The Health Security Act does not promote any predetermined organizational structure. The goal is to contain costs through better integration of care and continuous quality improvement. It is not to regulate providers through clinically intrusive and uncertain utilization review.

Health plans can improve the integration of care in many ways that especially benefit the most vulnerable populations. They can help patients receive the care they need and practitioners to provide care more effectively and efficiently. For example, managed care plans can provide more effective patient education programs because they serve populations of enrollees and the results can be evaluated. Further the use of high quality networks of providers makes selection easier for patients and assures practitioners of competent colleagues. Coordinating care across practitioners, institutions, and community services this becomes a more realistic possibility.

The leading managed care plans recognize that improving integration and focusing on quality of care are the keys to real cost control and better health for our communities. The Administration shares your concerns regarding potential underservice or inappropriate service.

MANAGED CARE IN HEALTH SECURITY ACT

To guard against potential problems, the Health Security Act requires plans to be responsible for meeting the health care needs of a defined population of patients, and restructures the insurance market to minimize risk selection. New plan development in underserved areas will be encouraged through policies that subsidize the development of local plans. Furthermore plans will have incentives to manage care in ways that are responsive to the needs of local communities and practitioners.

One of the most important aspects of the President's proposal for health care reform is the way it restructures both the personal health service and public health systems. This restructuring will increase our ability to improve the health of the public and reduce disparities in health status.

Key characteristics of the Health Security Act that enlist the personal health care system in achieving public health objectives include:

- universal coverage;
- comprehensive benefits including clinical preventive services without deductibles or copayments;
- new focus on populations
 - alliances and health plans are responsible for making sure that their populations have access to covered services;
 - national system of performance monitoring focuses the attention of health plans on achieving healthy outcomes for their enrollees;
- financing and payment systems that reward plans for keeping their populations well.
- an information system that links enrollment and encounter information that can detect underservice by plans.

MANAGED CARE AND PUBLIC HEALTH

With a reformed private delivery system, public health can focus on removing barriers to care for low-income, isolated, excluded, and chronically ill populations, through the Health Security Act's access initiatives. Attention to capacity building the communities to protect their populations against risks and address high priority local environmental, nutritional, and industrial health problems will be supported. These capabilities are strengthened by the President's proposal for public health programs which:

- strengthen the current safety-net programs and integrate them with private health plans;
- increase the supply of providers in underserved areas;
- expand capacity in inner-city and rural areas;
- provide additional support for outreach and enabling services that will enable people to get the care they need;
- support comprehensive education and health services for school-age children and adolescents;
- support community based prevention programs and core public health functions
- expand access to mental health and substance abuse treatment services.

The Health Security Act creates incentives for public health and personal health care systems to work closely together to create a seamless health care delivery system. This is particularly true for providers caring for currently underserved populations. Creating community practice networks that are integrated with private health plans means that the special needs of low income and chronically ill populations can be met more effectively. The essential community provider designation provides the mechanism for successfully integrating safety-net providers, school-based services, and private health plans.

CONSUMER PROTECTIONS

While recent research on managed care is encouraging, we must be vigilant to assure that all plan enrollees whether in indemnity or managed care receive high quality health care. Managed care plans by virtue of their very structure offer major advantages for assuring quality, offering cost-effective, and appropriate care that remain largely absent in indemnity programs. Additional consumer protection provisions in Health Security should prevent the types of abuses that are of particular concern to members of this Subcommittee.

Consumer protection is the heart of the Health Security Act. The Act incorporates safeguards to ensure that plans cannot reduce costs by denying necessary services. Health plans will not be able to choose enrollees, deny or reduce their coverage based on pre-existing conditions. Health plans will receive risk-adjusted payments removing the disincentives to enroll sicker patients. The performance of health plans will be monitored through report cards that focus attention on health outcomes.

Alliances will be governed by Boards composed of equal numbers of consumers and employers who purchase care in that area. Each will reflect the community it serves. The board will ensure that health plans serve all their consumers, are truthfully marketed, and fully disclose consumer rights and responsibilities. Ombudsman Offices at the alliance level will serve as advocates for consumers to resolve grievances in a fair and timely manner. Also, consumers will receive better care through administrative simplification, tort reform, improvements on clinical practice guidelines and quality measurement. Through these means, the Health Security Act will give consumers the knowledge and power to obtain high quality health care at an affordable price. The Act provides a comprehensive system of administrative and judicial review to ensure fair, accessible, and expeditious determinations of rights and benefits.

QUALITY ASSURANCE

The Health Security Act addresses quality of care in six ways:

- National quality measures will be established.
- Plans will be required to publish annual "quality report cards" that will allow consumers to compare the performance of each health plan within their alliance and choose their health plan based on these uniform quality measures and the premium cost.
- The Agency for Health Care Policy and Research will expand outcomes research and increase the development of clinical practice guidelines.
- Regional Professional Foundations composed of Academic Health Centers, Schools of Public Health, Plans and Providers will be at the center of continuing education of health professionals and dissemination of information to those who need it.
- States will establish quality criteria and certify health plans based on the criteria.
- Administrative simplification will reduce paperwork for providers and allow more time for continuous quality improvement.

Enrollees have the right to change plans annually or to seek services outside their plans under point of service provisions. These are choices that have largely not been available to Americans, especially those with low incomes. The right to select their own plan annually is a powerful way for consumers to influence the organization and delivery of services.

RURAL AREAS

The major barriers to physicians recruitment to rural communities includes professional isolation, the inability to take time off, few opportunities for continuing education and consultations by specialists, and access to referral centers.

Managed care programs can provide physicians working in rural settings with professional and personal support. For example, one west coast HMO has developed a network of rural physician practices to serve several rural communities. The physicians have access to consultations, weekend and night time coverage, vacation time, and air transport services to the plan's tertiary care facility.

Rural-based programs have been financially viable with relatively small enrollments. Early failures of some rural HMOs were due largely to poorly employed medical underwriting techniques. Penetration of managed care programs remain uneven but the President's plan should support the current trends that make health care more available to rural communities.

Summary

In summary, the Health Security Act supports continued improvement in the way we organize and deliver health care services, especially services for the most vulnerable populations--those with low incomes, children and adolescents and the excluded members of our communities.

Dr. Bruce Vladeck will discuss how managed care has been introduced into Medicaid and Medicare and relate what we have learned about consumer protections and appraising quality of care. For two decades, Medicare and Medicaid have been serving their beneficiaries through various forms of managed care delivery. During this time, we have learned a great deal about the advantages of this growing form of health care delivery. By the same token, we have also learned how to guard against the potential pitfalls of managed care. We expect to be able to apply this valuable knowledge to facilitate a significantly increased role for managed care in the United States under the Health Security Act.

MANAGED CARE IN MEDICAID

Managed care holds special promise for State Medicaid programs and their beneficiaries. To be blunt, fee-for-service medicine has not adequately met the needs large systems of the Medicaid population. Today's Medicaid beneficiary often faces great difficulty accessing care in the complex fee-for-service system. Many providers are reluctant to serve Medicaid beneficiaries and many Medicaid beneficiaries face cultural, language or other barriers to obtaining care from fee-for-service physicians.

As a result, many Medicaid beneficiaries use the emergency room as their primary source of care. Receiving care from a primary practitioner in a managed care organization is, without a doubt, a much better alternative for a Medicaid beneficiary than waiting in an over-burdened emergency room for care from a practitioner who may be unfamiliar with the patient's needs.

The use of managed care programs to serve the Medicaid population has become an important initiative on both Federal and State agendas. Faced with growing access problems, limited resources, and the need to make their Medicaid programs more efficient, an increasing number of States have found managed care programs to be practical and desirable alternatives to traditional fee-for-service delivery systems.

I'm sure you remember, Mr. Chairman, the first Medicaid managed care initiatives that began in the early 1970s as a response to the escalating costs of the Medicaid program. At that time, the managed care concept was a new one -- not only for Medicaid but for private insurance as well. As with most new programs, there were many kinks in the beginning of Medicaid managed care. There were abuses in some States including skimming, unscrupulous marketing methods, quality of care problems, and managed care providers who enrolled beneficiaries and then closed their doors to them because of financial instability.

But we've learned a lot since then. Over the past 20 years, States and the Federal government have responded to these problems by enacting more rigorous requirements. Federal demonstration funds were made available to develop a model Medicaid HMO contracting and monitoring system. Congress passed the Medicaid Health Maintenance Organization Amendments of 1976 to establish basic Federal quality standards for managed care plans. And to reduce barriers that made HMOs reluctant to participate in Medicaid contracts and States reluctant to experiment with managed care, the Omnibus Budget Reconciliation Act of 1981 gave States greater flexibility to contract with HMOs and explore other managed care approaches. And, TEFRA changed the Secretary's waiver authority to give States major options for developing managed care programs.

Forty-five States now serve Medicaid beneficiaries through managed care and the remaining States are planning to adopt some form of managed care arrangements in the near future. About five million Medicaid recipients are enrolled in managed-care plans. The number of Medicaid managed care recipients increased 33 percent during 1993 and has more than doubled since 1990. And some States, such as New York and California, are planning to serve at least half of their Medicaid populations through managed care by 1995. Clearly these are signs that the States are benefitting from managed care.

Let me relate a few examples from our Medicaid managed care experience that suggest a very hopeful future for this type of health care delivery.

- Through the use of prenatal care coordinators, Medicaid women in Alabama's Maternity Waiver Program can obtain prenatal care and begin care much earlier in their pregnancies. As a result, infant mortality decreased from 14.1 deaths per thousand births in 1988 to 11.9 in 1989. In addition, more Medicaid babies in Alabama are living to see their first birthdays.
- A similar program in South Carolina has reduced the number of extremely premature births and reduced the infant mortality rate from 13.2 deaths per 1,000 live births in 1986 to 11.6 in 1990. As a result, South Carolina saved \$3.2 million over the first two years of waiver operation, due primarily to reduced neonatal intensive care costs and inpatient hospital costs in general.

- Detroit's Comprehensive Health Services managed care program provides special services such as a high risk obstetrics clinic and childbirth education. This program had an infant mortality rate of 12.6 deaths per 1,000 live births in 1989, compared to a rate of 21.3 for the city of Detroit as a whole.
- And during the first five years of Arizona's managed care program, per capita costs increased at a rate substantially lower than that of traditional Medicaid. During this period, an evaluation of the program showed that hospitalization was reduced, quality of care for children more closely met professionally established guidelines, and beneficiary satisfaction was high.

Many State managed care systems have similar special outreach programs designed to bring low-income pregnant women, teenagers, and young children into care. Some also provide services not available to Medicaid beneficiaries in a fee-for-service setting, such as intensive case management with environmental and social assessments, child care, hotlines to the State agency for problems or questions, and substance abuse treatment.

HCFA requires that Medicaid managed-care plans cost no more than the amount that would be spent on comparable fee-for-service care and that they meet federal quality standards. Recently, HCFA issued guidelines for Medicaid managed care programs describing how to establish state-of-the-art quality assurance systems. In turn, the Kaiser Family Foundation has provided a grant to test these guidelines in three States. We believe that this work will be extremely valuable to the development and monitoring of managed care quality assurance systems under health care reform.

MANAGED CARE IN MEDICARE

Nearly three million Medicare beneficiaries have voluntarily chosen to enroll in HMOs. And this number is increasing as more people who are familiar with the advantages of managed care become eligible for Medicare. Medicare beneficiaries who choose the managed care option receive more services for lower out-of-pocket costs than beneficiaries who use traditional fee-for-service Medicare. The most commonly offered additional benefits are prescription drugs, preventive services, and vision and hearing care.

A study conducted for the Robert Wood Johnson Foundation in February 1991 cited managed care programs that have provided special arrangements for the elderly such as modifying physical layouts of their facilities to make them more user-friendly, evaluating the use of prescription drugs by the elderly to determine potential adverse interactions, employing primary care physicians with a special interest in serving older persons, and providing special training and information programs directed towards the elderly. The study also reported that many managed care organizations focus on training their staff specifically to meet special needs of the elderly.

Another study, conducted by Mathematica Policy Research in 1993, reported that quality of care in HMOs is comparable to that in fee-for-service, that 90 percent of HMO beneficiaries rated their satisfaction as either excellent or good, and that HMOs demonstrate the ability to utilize fewer resources than fee-for-service with comparable outcomes.

I want to emphasize that generally, Medicare managed care enrollees receive good care. Having said that, we also know that, in both fee for service and managed care, there is considerable variance in both quality and cost effectiveness. More to the point, we need significantly better tools to measure and monitor quality in all health care delivery environments. We have to improve the techniques we use to measure quality in all settings. I think our Medicare Quality Improvement Initiative is moving us closer to a new approach with improved quality assurance techniques.

Medicare has recently taken steps to create a state-of-the art model for appraising the quality of health care delivery for Medicare beneficiaries enrolled in managed care organizations. We are moving from evaluating individual episodes of care to a performance measurement system. We will focus on the application of continuous improvement techniques using information on the structure, process and outcomes of care delivered.

To develop quality-related performance measures for peer review organizations and HMOs to use, the Health Care Financing Administration has recently contracted with Delmarva Foundation for Medical Care, Inc. Delmarva will evaluate state-of-the-art measures to develop a new performance measurement system. This system will improve the way peer review organizations now review the quality of care delivered to the almost two million Medicare beneficiaries enrolled in risk-based managed care programs. A quality measurement system that improves the performance of HMOs and their providers is critical to ensuring quality health care for those enrolled in HMOs. By late autumn, we plan to begin pilot testing the performance measure, data, and methodology developed by Delmarva at selected HMOs prior to national implementation.

While HCFA is taking these steps to ensure high standards of quality for Medicare managed care, we are also concerned that the Medicare program and the American taxpayers benefit from the cost saving potential of managed care. To achieve this goal, we need to improve and refine the current payment methodology for managed care plans.

The Mathematica study I referred to previously indicated that HMOs spend roughly 10 percent less than if Medicare beneficiaries had been served under a fee-for-service arrangement. But the study also indicates that Medicare does not share in these savings and, in fact, pays almost six percent more for beneficiaries in managed care than it would have spent in fee-for-service because HMO enrollees tend to be healthier than the Medicare population as a whole. Beneficiaries with chronic health problems are less likely to change physicians and tend to remain in fee-for-service arrangements. Because Medicare managed care payment is based on payments in the fee-for-service setting, Medicare is not sharing in savings accrued by managed care plans serving beneficiaries.

In spite of these findings, we strongly believe that managed care holds promise for reducing Medicare spending. In order to make payment more equitable and more closely related to the actual cost of providing the care, HCFA has undertaken a substantial research demonstration effort to improve Medicare payment methodologies for managed care programs. For example, we have contracted with Boston University and Johns Hopkins to conduct research and to develop payment methodologies that recognize the health status of a beneficiary as a payment factor. Boston University will investigate predicting future Medicare expenses for an individual based on prior hospital use. Johns Hopkins is looking primarily at predicting future costs based on previous ambulatory care. The results of this research will help us adjust the amount Medicare pays a particular HMO based on health of the HMO's Medicare population.

We are also in the process of conducting a Medicare demonstration project to use HMOs as laboratories to test alternative payment methodologies that have been proposed or which may be developed as part of this project. Initially, this project will rely on new data reported by HMOs that will be used to evaluate the relationship between Medicare and non-Medicare costs. Beginning in 1995, the demonstration will test alternative payment systems which could include adjusting payments based on individual health status, providing additional payments for high cost cases, basing payment on HMO costs or HMO market prices, or making payment through negotiated contracting or competitive bidding.

THE HEALTH SECURITY ACT AND MEDICARE MANAGED CARE

Under the President's plan, managed care will provide America's elderly and disabled citizens with more health care options than they have ever had before.

Beneficiaries who are employed, or who are the spouse or the dependent of someone who is employed, will receive their health care coverage through regional health care alliances. These beneficiaries will be able to choose from among all the plans in their alliances.

Individuals covered under an alliance who become eligible for Medicare will be permitted to remain in the alliance - if the plan they are enrolled in has a risk contract with Medicare or is eligible to have a risk contract with Medicare. The Medicare program will pay the plan the same amount it would have paid if the beneficiary had enrolled in a Medicare risk plan. The beneficiary will make up the difference between the plan premium and the Medicare payment. Medicare eligible individuals in the alliance may also choose to leave the alliance and receive coverage from Medicare.

Medicare beneficiaries will have expanded opportunities to participate in managed care. To keep Medicare beneficiaries informed of the full array of managed care options available to them, Medicare will hold an annual open enrollment giving beneficiaries the opportunity to switch to new plans. During this enrollment period, beneficiaries will be provided with comparison information on every available managed care plan so they can make informed choices. This open enrollment will be conducted by a third party to prevent managed care plans from marketing selectively to healthier, low-risk individuals.

Beneficiaries will remain in the plan of their choice for the entire year. This allows managed care plans to more effectively and efficiently coordinate care for individuals and administer health plans without having to deal with changing enrollment on a monthly basis. The yearly enrollment also lets managed care plans know that beneficiaries who become ill will not be able to leave plans the following month to seek care in the fee-for-service setting.

In addition, Medicare beneficiaries who might be reluctant to enroll in managed care plans have the option of receiving managed care services on a point-of-service basis. Under this option, Medicare beneficiaries do not have to enroll in a specific managed care plan but can make a decision to receive the advantages of managed care at the time they actually need care. Medicare will contract with health providers to create a comprehensive preferred provider network in major metropolitan areas. Beneficiaries who choose this form of delivery will be able to make a choice whether or not to use the network on a service-by-service basis.

With a Point-of-Service option, beneficiaries retain the ability to use fee-for-service providers when they choose and are never worse off for not choosing to use the point-of-service network. The goals of this program are to expand beneficiary choice in managed care with proven quality and the ability to control costs. Incentives for beneficiaries to use Point of Service Networks can include financial and service-related benefits determined by the Secretary. For example, beneficiaries may have lower out-of-pocket cost sharing than would be the case under the traditional Medicare fee-for-service program.

As I explained at a previous hearing, States can apply to the Secretary for approval to integrate Medicare beneficiaries into their regional alliance or single-payer systems. We will approve such requests only if the State is capable of meeting certain strong guarantees. First, neither the beneficiaries nor the government will be financially worse off. Second, quality will be equal or better. And finally, at least one fee-for-service plan must be available to the beneficiaries at no greater out-of-pocket cost than they would pay under Medicare.

In summary, managed care programs have demonstrated their ability to meet the special needs of low-income individuals and the elderly. And we believe managed care offers a great potential for Americans of all ages and income levels to receive high-quality care at a more reasonable cost than they are currently paying. The Health Care Financing Administration has made a significant investment in serving Medicare and Medicaid beneficiaries through managed care plans and is currently undertaking intensive research and development to further our quality assessment and cost effectiveness goals. Our experience will be invaluable in implementing health care reform with a foundation of managed care.

* * *

FOOTNOTES

- (1) Tillman, I.A., Bagby, N.S., Garrett, J.B., "Market-based health care reform: well beyond the drafting table, Economic and Social Research Institute, October, 1993; Miller, R.R., Luft, H.S., Research on the cost effectiveness of managed care health plans: A literature analysis, University of California, San Francisco, 1993.
- (2) CBO staff memorandum, "The potential impact of certain forms of managed care on health care expenditures, August 1992.

Chairman STARK. I am somewhat disappointed. And, while your testimony is of some interest, the committee is faced with a problem where we had hoped the Department could be of some more assistance.

It has been a little over a year that the administration, working in secret, has been trying to develop a bill which we now have without any cost addendum, and we are being exhorted to write our bill in 6 weeks. And many of the Members have concerns about what we might do to protect beneficiaries, and you haven't really given us anything but some general outlines, really.

Bruce, in 1990, the Congress authorized physician incentive plans if they met certain regulations. In 1992, you proposed regulations for these physician contracts—and this is the key to decent control of managed care—and you still don't have the regulations.

Now, it would help us to have some idea of what we ought to put in legislation other than interesting platitudes and assertions as to how we are going to control it.

The Delmarva group, which you rightly say is studying something to help us with peer review, you neglect to point out that the bill abolishes peer reviews in 2 years, and we are then left with nothing.

It would be helpful if we were given some insight as to what ought to go in legislation to institutionalize some protections for people, and, as I say, particularly with the pressure coming off—I am sure the pressure is on you and us—get a bill out in 6 weeks, a bill that turns the care of Medicare beneficiaries over to private, profit-making operations with no quality control regulations, no financial regulations other than kind of platitudes. That certainly is a license to steal or you are asking us to be very irresponsible in giving you directions.

I would ask—for example, we have been trying for some time to limit the cost of outpatient reimbursement and had asked for a report, and, Bruce, I would ask you is there a report on outpatient reimbursement?

Mr. VLADECK. Mr. Chairman, on the prospective payment for outpatient?

Chairman STARK. Just go back. Is there an outpatient reimbursement report?

Mr. VLADECK. There is a draft report that is circulating within the executive branch.

Chairman STARK. How long has that been circulating? Like Diogenes out there, would you guess? 6 months? Or longer?

Mr. VLADECK. I think the most recent circulation has been approximately 6 months.

Chairman STARK. And the previous incarnation?

I don't mind that we are wasting \$10 billion a year in outpatient reimbursement if you don't, but one of these days some of my more conservative colleagues are going to start looking for that \$10 billion, and we are going to look very embarrassed.

It is our administration now and I am just suggesting by the same token in writing this legislation we need to have some details.

I would like to ask further—it is a concern to both Phil Lee and myself—but is it not the intent of the bill to suggest that if you are

eligible for Medicare and you have a spouse who is working in employment where they are eligible for health care which would cover you, you can't get Medicare. Isn't that what the law says?

Mr. VLADECK. That is effectively right.

Chairman STARK. That saves \$28 billion, does it not?

Mr. VLADECK. That is correct.

Chairman STARK. So that means—Phil, do you have Medicare? Dr. Lee?

Dr. LEE. I pay my premiums for part B, but, of course, as a Federal employee—

Chairman STARK. Now I hate to point this out—I will first confess that I would not be eligible for Medicare until I was 100. I believe it is 101, to be exact. You, sir, would not be eligible for Medicare if Carol went back to work.

Now, what I am suggesting is that that is not well-known. And my question is, why should we keep people out of Medicare at a higher cost to individuals? Because if my wife has to choose a higher-cost insurance plan for some reason of her health condition, I am stuck with paying 20 percent of her costs when I might pay far less in Medicare. And I don't think you are making that known, and I think those are the sorts of issues that we have to discuss.

Another issue, Bruce, is this: In the bill, and you mentioned it, you bragged on this, that people will be in these risk contracts for a year, as you will see. And we are going to distribute hundreds of these Florida copies. The only salvation that our beneficiaries had when they got in with these shysters like Prudential and Aetna and Humana to get out and get treatment was to drop out because Medicare allows them to get out in 30 days.

Now, why in God's name would we want to lock somebody in for a whole year to a plan that won't give them decent care? I cannot understand why you talk about that as a benefit. That is a restriction on our Medicare beneficiaries—unless you have some alternative—and you don't. You have an ombudsman. But by the time you get to the ombudsman, my mother will be dead.

And why would you want to lock somebody in and not make sure that the provider has quality so people can get out? What is the reasoning behind that?

Mr. VLADECK. Well, I think there are three reasons for that, Mr. Chairman. The first is that the ability to sort of disenroll on demand has served as an excuse, frankly, for us as well as for others not to do the kind of quality assurance and quality monitoring nor to invoke—

Chairman STARK. You mean it is a proxy for quality?

Mr. VLADECK. We have used it as a proxy for quality and as an excuse for not directly measuring—

Chairman STARK. That is fair.

Mr. VLADECK. —and, frankly, as an excuse for not using, as I have just learned in the last several weeks, the authority to invoke intermediate sanctions on Medicare contractors which we have had for a number of years and where we have been between the proposed regulation and final regulation stage for quite some time.

And part of the excuse, as it were, has always been, well, if people don't like it, they can just leave. And so it has been a way,

among a number of the reasons, why I think our organization has not historically lived up to its responsibility.

Chairman STARK. OK, now, seriously, my object is not to beat up on dedicated, hard-working professional bureaucrats. The point is, why should we institutionalize an incomplete system in what is being heralded as a revolutionary reform? Wouldn't it say, in the point of the peer review or the 30-day opt out, leave that in until we have some evidence that alternative controls are working?

And that is the kind of thing that this committee needs from you all to help us write a bill. Because it isn't in the bill now. And, arguably, the protections, if they are not there, if you remove the protection of disenrolling with the absence of any defined quality control standards, and there aren't any, I don't think that is responsible. And I don't think I can ask my colleagues to just say let's turn the sheep loose among the wolves of the HMO managers, and it is a concern.

So when I criticize your testimony, the point is we need help to provide the legislation under which you are going to have to draw these regulations, and there isn't any to speak of in H.R. 3600, so I hope we can get you back. It doesn't have to be in open session, but we do need that assistance if we are going to write anything that will face the ridicule test of the provider community.

Mr. VLADECK. Can I just make one comment about that and then turn it over to Phil?

If, sir, you write the bill in 6 weeks and we enact it by July 1, we will then have 18 months before the first State begins implementation under the act. And part of the issue on timing here, as you know, particularly when one is talking about the Federal executive branch agencies. There is a certain chicken-and-egg phenomenon, and the question is not whether we have in hand now everything we would need in order to make the program work as it is designed, but what the reasonable expectation would be of having it in place 18 months or 24 months or 30 months. And I think we can deliver on most of what we—

Chairman STARK. Bruce, do you know how long it took Prudential to steal hundreds of millions of dollars from 18,000 investors in their company? These guys are creative. And the minute we give them license to start signing up our beneficiaries—as I mentioned the woman with dementia. These are fragile people for the most part.

If you think south Florida in Clay Shaw's district has troubles now, just open the floodgates without any regulation. I understand that it takes time for these things to clock in, but it doesn't hurt.

Do away with peer review while we hope we will get something in time? The alternative might be to say leave peer review in place until the Secretary can certify that there is a workable alternative, I could buy that, and give you all the choice.

But I think we need to work to say that—without going to the question of the philosophy of the bill or the overall structure. We are talking about the details now. And assuming we wrote that bill as it is, it needs a lot of additional distinction and regulation, and that is what I had hoped we would get from you today, and we are sorry.

Mr. VLADECK. We would be happy to work with you starting tomorrow.

Chairman STARK. Great.

Dr. LEE. Mr. Chairman, you asked what could we do to protect beneficiaries. I think that has been the whole thrust of your comments.

Chairman STARK. And the taxpayers. These guys will steal our money by not providing care usually. That has been the record of managed care.

Dr. LEE. In the Health Security Act I think we have gone farther than in any previous attempt to deal with the quality issues and to provide mechanisms.

First, the standards that are in the bill. Critically important is the development of data systems that provide the information both to physicians, to the plans, and to the consumers.

And one of the things that is happening very rapidly in places like Kaiser Permanente, for example, is they are moving to develop encounter data within their plan. In the past they did not have that, and, again, David Lawrence, in discussing this with me, has said the reason they need that is to improve the quality within their own system.

Chairman STARK. Do you know the difference between Kaiser's overhead and the general overhead of most HMOs in managed care? I like Kaiser. It isn't all pure because they do a lot of risk selecting, but let's get over to the for-profit guys who got hit with a \$79 million judgment for withholding a bone marrow transplant to a woman. I mean, those are the kinds of folks I have got to worry about.

Maybe I could convince my colleagues that Kaiser in my district is a reputable operator, but you are going to have a little trouble convincing me that Humana, Prudential, Aetna and the others are because their record of really withholding care to make a profit is well documented. And I think that that is what we have to watch out for.

Now, all of these theories will work fine some day, but I am just not willing to put the fox in the hen house from the get-go until we know that that won't happen.

Dr. LEE. Well, I think that is one of the reasons—in the bill we do include—or in the proposed act—the data and the quality standards. And another is the linkage between public health and creating a public health infrastructure that can do data analysis, can do assessment and assurance so that plans can be evaluated in terms of their performance.

Chairman STARK. Do you give the beneficiaries the right to sue the gatekeeper if they deny care, give them standing to sue? I will trade you that. Just give any beneficiary standing to sue the gatekeeper, whomever that may be, who denies them access to service that subsequently is determined was necessary and withheld. If we do that, we could skip a lot of the rules.

Dr. LEE. In the bill there is a fair amount of detail.

Chairman STARK. Do you have that in the bill?

Dr. LEE. Well, in the bill there is a procedure with respect to medically necessary and appropriate—

Chairman STARK. Why don't we just give them standing to sue?

Dr. LEE. They do have the authority to sue. It is in the bill. They can bypass the administrative procedures. But there are administrative procedures, again fairly detailed, that provide, we believe, significant consumer protections, but they also have the authority to sue.

Chairman STARK. The gatekeeper?

Dr. LEE. Sue the plan. They could sue the physician. They are not denied that in the bill at all.

Chairman STARK. With no tort limits? So if we do that—

Dr. LEE. I don't believe there are any tort limits.

Chairman STARK. If we do that, I think we can skip a lot of the regulations.

Mrs. JOHNSON. Mr. Chairman, would you yield on this point?

Chairman STARK. Yes.

Mrs. JOHNSON. It is my understanding that in the President's bill there is an explicit prohibition against suing on the issue of guidelines either the National Board or the plans that have implemented the protocols adopted by the National Board.

Chairman STARK. There is. You are right.

Dr. LEE. But those are practice guidelines.

Mrs. JOHNSON. The rubber is going to hit the road on this issue.

Dr. LEE. But we don't have practice guidelines yet in many areas.

Mrs. JOHNSON. But we will. That is the whole goal.

Dr. LEE. Well, we will be developing those rapidly, and, of course, many professional organizations have developed those. But there is in the bill these consumer protection provisions which are, I think, important when there are not agreed-upon guidelines.

Mrs. JOHNSON. My point to the chairman is that, as important as those are, that in the end what we are all talking about in health reform is some way to manage volume more rationally than under the current system. In all the other proposals we deal with that effort to manage rationally.

The goal of malpractice reform is to help release the system to manage more practically, but the Health Security Act is unique amongst all of the proposals in this area by denying the right to sue to patients who are affected by the guidelines.

Now, I will get the language at some point, Mr. Chairman, for you, but I believe that this is one of the really radical aspects of this proposal that the public is not aware of, and I wanted to be sure to bring it out.

Thank you, Mr. Chairman.

Chairman STARK. Thank you. And the gentlelady is quite correct. While we may differ on the issue of tort, my feeling is, in the absence of regulations, I would just as soon let the trial lawyers regulate. They will bring more fear to the hearts of these managers of HMOs than HCFA because they are tougher. That is, a \$79 million fine gets their attention. The threat of a sanction that goes on and on and on and on is not really as realistic, so it might be—

I am sorry. I have far gone over my time.

I appreciate Mr. Thomas's patience. Bill.

Mr. THOMAS. Mr. Chairman, if you want some more time to continue your line of questioning, I am more than willing to let you continue. This is kind of interesting.

I guess I should start with a disclaimer saying that the following comments are not intended to defend or support the administration or the bill it has introduced. However, I thought your testimony was helpful.

I think we are all in a dilemma. And that is, as we develop more and more of these new and novel structures, we are obviously playing catchup on the tools to evaluate, compare and measure.

One of the frustrations I have, Dr. Lee; in your testimony on page 11 you list some quality assurance things that the President's bill has. I can tell you, the Chafee-Thomas bill has six identical structures. A number of other bills are focusing on exactly the same problem.

The problem is we are trying to write a bill without the collection data tools necessary to feel comfortable at this stage on the kind of very firm specific regulatory suggestions that the chairman said that he needs to write a bill in 6 weeks.

I am just saddened that we didn't last year pass a package of provisions which would have given us administrative simplification, the beginning of the computerized collection of data, some kind of a malpractice reform, open up antitrust and do some of those things that would provide us with a sound basis for going ahead and evaluating.

For example, Dr. Vladeck, you mentioned the Mathematica study that has been mentioned a lot. My difficulty, from an approach of examining the facts, and the methodological structure of it, is that sometimes it is hard for me to really believe that they are comparing the same thing when you have a fee-for-service and the HMO, and compare the beneficiary packages and the structure. And you indicated that the savings that are, in fact, being created under the Medicare HMOs are not being passed back through Medicare.

Don't you agree that that is probably not a flaw in the structure? It is a flaw in the formulae structure of what you are measuring and how you measure it.

For example, if you would change the adjusted average-per-capita cost formula, you might be able to have that pass through. That is a time problem, adjusting to a structure change. Is that a fair statement?

Mr. VLADECK. That is absolutely correct.

Mr. THOMAS. When you look at the changeover from the managed care in the Medicaid areas—

You mentioned New York, California and Arizona. I think we are going to have testimony. They have labored long and hard in this field, and they have been able to come up with separate rates for what are essentially healthy and nonhealthy and have been able to get a better handle on true comparative costs in terms of programs, and this is a time lag program.

What concerns me is that we rushed to judgment over first and second generation structures when, in fact, we are into the third and need to move into the fourth. And the problem is we do not have at the Federal level, and precious little at the State level, any kind of research or data-collecting tools to be able to get a handle on the flow.

That is what part of the President's bill is about. But I want to underscore that is what everybody else's bill is about as well. And

we can sit here and commiserate about specific anecdotal examples of problems, but I don't know that that advances our need to collect the data, either.

We ought to pass a pared-down bill which gets us that a year, 2 years ago so that we would now be sitting here debating the relative validity of different statistical examinations of these structures to move forward with regulations.

And that is part of my frustration in terms of beating up on you guys because I can do that, too, but I don't think it advances the need to collect the hard data to be able to set up the kind of structures that would allow us to compare more equitably, and, second, to then make the changes to make sure that what everyone wants would occur.

Mr. VLADECK. Let me clarify one issue if I may, Mr. Thomas, and that is, in terms at least of the Medicare and Medicaid programs and increasingly in terms of the private sector as well, our problem in developing the methodologies and the tools to move ahead in the way both you and the chairman have suggested is not one of access to data. It is not one of information.

Frankly, for so long in our organization and others managed care was treated as a matter of faith, not of fact. You either believed or you didn't.

As we develop a more mature sense of this and want to refine our measurement techniques, our payment techniques, it is really just a question of time and resources to develop these tools. We have all the data. We can get all the data we need in our current activities. We are increasingly talking about getting data from the private sector. In the current budgetary and staffing environment it is just a question of how many resources you can put into this over what period of time.

But we are, with or without the passage of legislation that speaks to these research issues, we are in a position to move ahead as quickly as possible on these areas.

Mr. THOMAS. As Dr. Lee stressed, those structures that are, frankly, more responsible are anxious to prove an internal ability to measure quality so that they can be separated from the others, and you are going to see a private sector move in that direction in terms of collecting data as well, I would assume.

That is one of the things that concerns me about trying to move to one size fits all or to basically approach negatively other structures because, frankly, the tools to be able to compare and contrast against significantly different structures is going to be something that, to a certain extent, we are going to have to accept on faith to begin with unless you believe that your view of the world, your particular model is so superior that it should supplant any others. I am just as concerned about that particular mental set in terms of trashing everything else out there because it isn't yours, and as we move forward, I look forward to you folks developing tools so that we can assess on a more rational basis a comparison.

I am just sorry that we didn't set some bases last year so that we can continue to move forward, but I want to assure you that anyone who is interested in this area, in the area of quality assurance of collection of data, there is no difference in any of the legis-

lation. We are all anxious to try to provide that kind of a sound base to move forward.

Personally, I thank you for your testimony.

Chairman STARK. Mr. Kleczka.

Mr. KLECZKA. Thank you, Mr. Chairman. I have an excerpt from a New York Times article dated December 27, 1993, in which they indicate the Clinton administration officials say they will not prod elderly Medicare patients to join HMO organizations in part because they have discovered that Government loses money on people enrolled in such private health plans.

Now, Bruce, you made reference to the Mathematica study in your remarks. The concern I have is that under the President's bill we will continue Medicare as we know it, and hopefully add the drug benefit. However, the whole setup of the bill would encourage this population to go to the regional alliance and buy an HMO plan, is that not true?

Mr. VLADECK. I don't know, sir. I think——

Mr. KLECZKA. We had people that have come before the committee and testified to that. The Chairman is convinced of it. But, let me have your response first.

Mr. VLADECK. Well, again, there are people in various statuses, and it is true, as the chairman suggests, that Medicare beneficiaries who are working or who are the dependents of folks who are working will be in the alliance choice structure rather than in the Medicare program.

It is also true that there will be some incentive for recently retired persons to stay in alliance plans rather than in the Medicare program, but, frankly, sir, I think the whole point of the President's proposal, both for the working age population and for the Medicare population, is to really give informed choices. I think it is in our written statement, and it fell between the cracks between me and Dr. Lee in our oral statements. I don't think the Health Security Act presumes one outcome or another in terms of the kinds of plans that are going to prove most successful or most popular.

I think what we are committed to is setting up a level playing field, a fair marketplace, whatever the appropriate metaphor is, with good information, and empowering consumers, whether they are employees or Medicare beneficiaries, to make informed choices, and to require the plans to live in a world in which they are dealing with more knowledgeable consumers who have alternatives.

Now, who will succeed and who will not in that environment, I think if we knew it, we wouldn't be consistent with the principles underlying the plan, which is to create some real and fair competition and to let consumers decide.

Mr. KLECZKA. I buy all that, but it doesn't address my concern. My concern is if the reform bill shifts people to HMOs versus staying in the Medicare program, and if as Mathematica indicates, the Government would be paying more in the HMO than Medicare, what changes do we have to effectuate to make sure this doesn't occur?

Mr. VLADECK. We have been very explicit that we need a new payment methodology for Medicare risk contracts.

Mr. KLECZKA. OK.

Mr. VLADECK. There is almost uniform agreement not only between ourselves and OMB and CBO and other governmental agencies and the academics, but with the industry as well, that the APCC probably underpays efficient plans and overpays inefficient plans and all sorts of things in between. We have a range of activities which, again, are detailed in the statement. I could mention some of them.

We have a demonstration project with seven HMOs just underway in which we will begin collecting extensive data about both the patterns of service and the costs of service and the patterns of enrollees, and we begin on January 1, 1995, testing five or six new payment methodologies.

Mr. KLECZKA. But our problem is we are going to start marking up a bill on March 1. Are you going to have any recommendations for us as to what changes we should put in that legislation?

Mr. VLADECK. Well, I don't believe it makes sense in general for the Congress to legislate in great detail, as has been the case with APCC payment methodologies. I think if you give us—

Mr. KLECZKA. Leave it to rules?

Mr. VLADECK. [continuing]. Guidance, by January 1996, we will have a better methodology.

Mr. KLECZKA. The Chairman indicates that as far as rules go, your agency hasn't been the most expeditious, but nevertheless we will look at that. Thank you very much.

Mr. VLADECK. We are changing that.

Mr. KLECZKA. OK.

Chairman STARK. Mr. Lewis.

Mr. LEWIS. Thank you, Mr. Chairman. Dr. Lee, what are some of the possible methods for protecting consumers in a managed-care facility? How can we assure that consumers are not receiving inadequate care in an effort to conserve finances, the oft heard stories about primary care doctors, the gatekeeper or the managed-care executives being offered rebates if they don't refer, send patients to specialists.

Dr. LEE. The provisions in the Health Security Act, I think, go farther than the current system to assure those who in the past have been and today, many are underserved in terms of the care they receive—the quality standards, the development of data systems, the quality report card which would provide information to consumers about whether or not a plan is appropriately serving those individuals. In other words, the requirements for the report card will include information about services provided, about the providers in the plan, and about outcomes, so that we will be able to provide it to consumers and in addition to State health departments and, indeed, in some cases perhaps even to local health departments of a size. For example in Los Angeles County, we will be doing what is considered a core public health function, that is assessment and then assurance, and they will be evaluating plan performance.

Let's just take immunization as an example. We found in the measles epidemic in the 1980s, and this was true in Milwaukee, where HMOs were underserving and not providing immunizations working with the local health department. They have developed a cooperative arrangement where, in fact, in that case the health de-

partment is providing the immunizations and the HMOs are contracting with the health department to do that. That was because of the surveillance system that indicated who was and who was not being immunized. In the plan we will have a method for doing that, not only for things like immunization and other preventive services, but for other critically important medical services for, let's say, chronically ill patients. I think that a combination of consumer information, the quality standards that are built in, and finally the role of the health departments in making these assurances in terms of achieving these plan objectives all help. But also in the plan in title III, we have the access initiative with safety net providers and with capacity expansion. Many patients now don't have access to necessary care because providers aren't available, so they must go long distances in their communities to a public hospital to get services in an emergency room.

Part of that capacity expansion would be to assist the communities in developing practice networks in those low-income, inner-city areas and also in rural areas to meet those needs and to make assurances that providers are, in fact, available to serve the needs of those populations. So I believe these requirements will go a long way. But at the Federal level also with the National Board and with its oversight functions we have to assure that we, in fact, are achieving those objectives and providing protection for all of us, including those who are currently disadvantaged in terms of access to care.

Mr. LEWIS. Dr. Lee, do you believe there are effective ways and means to really measure outcome; that is, to give consumers an opportunity to review managed-care facility performance in terms of quality health care?

Dr. LEE. Well, I would say we are at an early stage of development in terms of performance measures, and one of the major things we will be doing is to work to develop better performance measures, but there are some areas where we can clearly do this today. And again I would cite immunization, but there we can measure whether a plan does, in fact, immunize children up to the age of 2 or an appropriate age level, and second, we can gather data, as we do now, in the community to determine whether, in fact, there are any cases of measles, whooping cough or other preventable infectious diseases that if the children were immunized, those diseases would not occur. So we will have several measures.

Now, that is one area. For a number of areas, we are at an earlier stage of developing, and we have process measures rather than good outcome measures to assess good plan performance.

Mr. LEWIS. Dr. Lee, in my district, I have many minority health providers, and some are telling me that already they are being shut out of these networks. Can you give me some message or some word that I can reassure these minority health providers that they will not be continually locked out of these growing networks?

[The following was subsequently received:]

Statement for the Record

Clarification of the statement of Dr. Philip R. Lee regarding protections for minority providers:

The Health Security Act (HSA) includes both direct and indirect provisions to prevent health plans from discriminating against minority providers and their patients.

Direct Protections for Minority Providers and Their Patients

The anti-discrimination provisions that apply to health plans in the HSA are strong. They cover both intentional discrimination and acts that have the effect of discriminating. In addition, the HSA specifically prohibits health plan discrimination against providers based on the personal characteristics of the provider of the provider's patient's. Section 1402(c)(2) states:

"In selecting among providers of health services for membership in a provider network, or in establishing the terms and conditions of such membership, a health plan may not engage in any practice that has the effect of discriminating against a provider -

(A) based on the race, national origin, sex, language, age or disability of the provider; or

(B) based on the socioeconomic status, disability, health status, or anticipated need for health services of a patient of the provider."

Additional Protections for Minority Providers

In addition to the general anti-discrimination provisions, the HSA includes several provisions designed to ensure appropriate access to care and choice of plans for minority patients and to ensure that minority providers may participate in health plans.

1. States are required to ensure that all families have adequate access to enroll in a choice of health plans in their area (including adequate access to low cost plans). States may require one or more health plans to cover the entire service area of the regional alliance. States also have the authority to use financial incentives to ensure that health plans enroll members of disadvantaged groups.

2. Under the HSA, fee-for-service health plans must pay any lawful health care provider of the enrollee's choice, regardless of whether the plan has a contract with the provider. A fee-for-service plan may exclude a provider only if it has evidence that the provider renders poor quality care. Because every regional alliance must offer at least one fee-for-service plan, every provider will have the opportunity to participate.

3. The HSA preempts state laws which require health plans to contract with any willing provider, except for services provided on a fee-for-service basis. Thus, existing state laws which require health plans to contract with any provider who is willing to meet its terms remain in force for fee-for-service plans and for the fee-for-service component of other types of health plans. And, of course, the anti-discrimination provisions described above apply to all types of health plans.

4. The Essential Community Provider provisions in the Act ensure that vulnerable populations will have access to providers with experience in meeting their special needs, regardless of which health plan they choose. Under the HSA, many Public Health Service grantees that serve vulnerable populations are automatically certified as Essential Community Providers (ECPs), and other providers serving underserved populations may apply for certification. Health plans must either contract for payment with any ECP in its service area; or if there is no contract, the health plan must pay the ECP under the regional alliance fee schedule or at applicable Medicare rates.

Dr. LEE. Yes, that problem has arisen. I have had long discussions with physicians in the San Francisco Bay area over the last few years. That problem is not limited to Georgia. Two things, I think, in the plan that would prevent that.

First, our very strong civil rights protections so that the Civil Rights Act cannot be violated with respect to the opportunity for these physicians to participate and any barrier that is based on race or gender would be assured in the plan.

Mr. LEWIS. What about location, areas, zip codes, certain areas of a city or metropolitan area?

Dr. LEE. There is one other provision, and that is the any-willing-provider requirement in the bill, that any willing provider can participate in the plans unless it is a closed-panel group practice where they don't have a need for an additional physician, let's say, in the plan.

The red lining which has occurred in the past will be prohibited. The plans will be required to provide, to offer the plan to everyone within an alliance area at the community-rated premium for that plan, so that those provisions should help to increase access both for the individuals living in those areas, but also to assure the physicians or other nurse practitioners or other providers who work in those areas and serve patients in those areas that plans will be available and they can participate in the plans.

Mr. LEWIS. Thank you very much, Dr. Lee. Thank you, Mr. Chairman.

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON. Thank you, Mr. Chairman.

This is a very big issue that my colleague from Georgia brought up, and we can't take it on right now. First of all, it isn't directly the subject of this hearing, but your responses, Dr. Lee, while interesting, really only scratch the surface. The any-willing-provider provision is in direct contradiction to the whole concept of accountable health plan capability to serve a whole area, and right now in rural Connecticut—I know that most of you don't think that we are very rural—I have networks that simply don't have the capital to invest in expanding themselves to our sparsely populated areas.

It is exactly the problem we had with cable television service, and if you are going to enforce a national any-willing-provider requirement, then you are going to eliminate the concept of managed networks, so these are difficult problems.

This is one that I personally believe is totally unresolved and have urged my legislature and my State to pass any-willing-provider legislation, although all of the managed-care providers in my State are wild about that idea, as are the hospitals because now they are developing networks, so they say don't drop this. This is far bigger than any civil rights protection could address, and I would have to see the language of your any willing provider unless the panel has such and such wording in the law, because I think this is a big issue yet to come, but it is a big issue under any plan, not just the President's plan, although it is a bigger issue under the President's plan than others.

Let's get back to the subject of this hearing, which is managed care, and another issue that your comments have raised that is not unlike the issue that the gentleman from Georgia raised. Do we

have any evidence that the problems in the managed-care plans are of any greater dimensions than those same problems in the fee-for-service plans.

Do we have any data that indicate that the fee-for-service system doesn't have exactly the same problems that the managed-care system has, but we don't have the documentation? Have we ever done a single study on denial of care in the fee-for-service sector? We have enormous information about it.

Medicaid is a living example of denial of care in the fee-for-service system. We had to pass legislation to require emergency rooms to take people on public plans, so, we also have some information, I believe, in the nonpublicly subsidized health care system on these kinds of issues. And our information in the managed-care sector is very incomplete because of policies like those that Kaiser has always followed that deny us any information about dissatisfaction.

In fact, the malpractice system gives us far more information about these very same problems in the fee-for-service system than we actually have in the managed care. Would you care to comment on that?

First of all, I think your testimony was excellent and your understanding of the value of managed care and its advantages as enumerated on page 5 gives me great hope because it says to me that actually Washington isn't out of touch, that you have the ear to the ground, you see what is happening.

You understand what is happening, even though, in fact, our data collection and research systems are sufficiently behind the curve so that we do not have the data, but we are so far behind the curve that we haven't looked at these same issues in the fee-for-service sector, either. My specific question at this point is do we have any evidence, any hard data that the problems we have been talking about in managed care don't also exist in fee-for-service, and do we have any data that would indicate that those problems are either more or less severe in managed care than they are in fee-for-service?

Dr. LEE. I would say we have a good deal more information on fee-for-service quality, and one of the big issues there, of course, is overprovision with the incentives that are in the fee-for-service system, and the problems that arose early with some of the managed-care plans that Bruce noted were underservice, enrollment of individuals, denial of service, and patients then going to the emergency room when they couldn't access the HMO that they were enrolled in. So the underservice on the side of managed care is the potential problem.

Overutilization and overprovision of services is clearly a problem in fee-for-service.

Mrs. JOHNSON. Dr. Lee, what are the studies that have been done in rural areas to look at these issues of underservice, even denial of referrals in less sophisticated areas where specialty care isn't as accessible?

Dr. LEE. We can give you, for the record, some detailed information, but basically the shortage of providers in many rural areas is one of the reasons that we have in the plan the access initiative with expansion of capacity, which would provide grants, loans, and loan guarantees to create community-based practice networks in

rural areas as well as inner cities. It would help to overcome that problem. But there is, I think, ample evidence that people living in rural areas utilize services less often because there are fewer providers available.

There are some specific problems for the elderly; for example, transportation. Many elderly do not own an automobile, so their access to care has been somewhat reduced because of that. But we will provide for the record some detailed results of specific studies on access and quality in rural areas.

Mrs. JOHNSON. Have you done any studies of malpractice cases that have to do with denial in the fee-for-service system, and any comparison of denial as seen through malpractice cases or through the negligence study in New York versus evidence of denial in the managed-care system?

See, I don't think we can prove that yet. I don't think we know that yet.

Dr. LEE. I don't know of any specific studies.

[The following was subsequently received:]

RESEARCH ON RURAL HEALTH

ACCESS

Information about the problems and trends in rural health services and the availability of health care providers and facilities in rural America can be found in:

Health Care in Rural America Office of Technology Assessment, U.S. Congress, September 1990

Additional information about the supply and distribution of health professionals in rural areas can be found in:

Health Personnel in the United States: Eighth Report to Congress Health Resources and Services Administration, Public Health Service, U.S. Department of Health and Human Services, 1991, and

Study of Models to Meet Rural Health Care Needs through Mobilization of Health Professions Education and Services Resources, a study prepared for the Health Resources and Services Administration, Public Health Service, U.S. Department of Health and Human Services, June 1992, by the National Rural Health Association.

These studies show the shortages of health care providers in rural areas relative to metropolitan areas. For example, in 1988 28.4 percent of the rural population lived in areas designated as having a shortage of primary care physicians as compared to only 9.5 percent in non-metropolitan counties.

Moreover, managed care systems are not well developed in rural America. In 1992, 64.2 percent of rural counties did not have an HMO providing services to their residents and that percentage was much higher--77.1 percent in counties not adjacent to an urban area. (See: Wholey, D., Information prepared under the Health Care Financing Administration Cooperative Agreement 17-C-90055-3-01, "The Effect of Market Structure on HMO Finance." 1993.)

The link between provider shortages and utilization rates is not completely clear cut. While a five-State study of rural versus urban hospital access for Medicare beneficiaries suggest that rural residents do not appear hindered from receiving inpatient hospital care, rural residents frequently have to travel to urban areas or rural referral centers for specialized medical care and technology-intensive patient procedures. (See Utilization of Inpatient Hospital Services by Rural Medicare Beneficiaries, Codman, Research Group, Inc. ProPAC Extramural Technical Report No. #91-03, May 1991.)

The National Medical Expenditure Survey (NMES), conducted in 1987 by the National Center for Health Services Research (now the

Agency for Health Services Research) found referral visits per capita in the largest 19 urban areas about 60 percent higher than in rural areas. In other urban areas, the referral rates are about 15 percent higher than in rural areas.

Moreover, for certain populations access problems are severe. One striking example is found in coronary angioplasty. A recent study of Medicare beneficiaries found that among whites, the rate for use of this procedure was similar regardless of their urban or rural residence. Among African-Americans, however, the rate of use was 10 times higher in urban areas than in rural areas. Urban whites were 2.5 times more likely to have this procedure as urban African-Americans, but rural whites were 20 times more likely to have this procedure as rural African Americans. (See American Journal of Public Health, July 1993, Vol,83, No. 7, p. 951)

TRANSPORTATION

The 1987 NMES also found that 13 percent of rural elderly travel more than 30 minutes to their doctor's office. The comparable figure for urban elderly is 7 percent.

The Community Transportation Association of America reports that half of rural counties do not have a public transit system; more than half of the rural poor do not have a car of their own; and nearly 60 percent of the rural elderly do not have a driver's license.

Mrs. JOHNSON. Denial, as a matter of availability, is different than denial of the type you are suggesting in managed care. I don't disagree that there are incidents, but I think to base national policy on the assumption that somehow managed care denies more aggressively than fee-for-service can't necessarily be supported. And the other half of that is that we need information on how managed care has expanded availability, encouraged prevention, encouraged people to come in more frequently under certain circumstances, because in my district I have some hard evidence of that versus fee-for-service that has neglected wellness and prevention. So until you have those two sets of figures, you can't base national policy on the assumption that managed care is more prone to deny needed care than is fee-for-service.

When I said what I had to say had some bearing on the gentleman from Georgia's comments, unless we know this information, then we are likely to plunge ahead writing Federal regulations that will be so burdensome on these performance measures, and remember we are always three years behind. Managed care wouldn't be growing at the rate it is growing in both the public and private sector if its rate of dissatisfaction was far higher than the private sector, and for us to come in 3 years later and 5 years later and 8 years later and say that we can now regulate better than people can tell about quality is worrisome to me.

I certainly want to be part of outcomes research and those kinds of profiling things and the information that consumers need, but I am very concerned about the increasing willingness of Government to believe that it can make the very judgments that the public has been making in the last few years successfully better than the public can when we weren't even smart enough to look at the right data 3 years ago in either managed care or fee-for-service to have the information we need now on which to make public policy.

Now, let me ask specifically because 3 years ago there was some enlightened thinking on this issue. Medicare radically altered the nature of utilization review, and went from utilization review being an over-the-shoulder critic, you shouldn't have let them out of the house so early. You shouldn't have given them this test. You shouldn't have treated them with this procedure to a profiling agency that looked at patterns of practice for individual providers and hospitals to developing the very information that my colleagues are interested in.

I sat last night next to the head of our Utilization Review Commission in Connecticut, and he is very excited about what they have done, and yet you haven't mentioned that at all today, either in regard to our ability to oversee Medicare risk contracts, Medicare as a system, quality for both public and private providers, and I know you are doing it. I would like you to talk about it. I would like to see how that is going to affect our ability to manage some of the problems we have talked about.

Mr. VLADECK. Well, I did make reference in my oral statement, Mrs. Johnson, to the work we are doing with the Delmarva Peer Review Organization, which is part of the same process.

Mrs. JOHNSON. Sorry, I wasn't familiar with that, I didn't know what Delmarva meant.

Mr. VLADECK. Second, we are, while Delmarva is developing new standards, the pros continue to do review of performance of managed-care plans using the same criteria that they are using for the fee-for-service sector. As we transform our review of fee-for-service cases, we are doing exactly the same thing for managed care plans.

Mrs. JOHNSON. Outside of the Delmarva reference, since I am not familiar with that, isn't it true your peer review organizations in every State are now doing profiling?

Mr. VLADECK. That is correct.

Mrs. JOHNSON. What are you learning from that and what has that enabled you to do in regard to managing cost and quality in Medicare?

Mr. VLADECK. It is too early to say. The first contracts for the scope of work under which that process changed were let in the second half of last year, and we are just now gearing up some of the last ones in the cycle. So we are about—it is about 6 months too early for us to tell.

Mrs. JOHNSON. Are you looking at whether profiling can be used to affect volume of services positively?

Mr. VLADECK. The intermediate question is whether the way in which we provide profile information to physicians and other providers in a given community produces behavioral change on their part when it is given to them by the pros, and we will begin to have some experience in that regard in the next 6 months or so.

Then the question is what kind of change does it produce? Do they reduce the volume of services or do they change the way in which they report the medical records? We will know that in the near future.

Mrs. JOHNSON. Then of course the question beyond that is, is the reduction in the volume of services good for the patient? Which services are they reducing?

Mr. VLADECK. That is exactly right. That is why they have to keep tracking it.

Mrs. JOHNSON. So you are really very much at the beginning of this process?

Mr. VLADECK. I think that is fair to say, yes.

Dr. LEE. Mrs. Johnson, if I could comment also, in the Health Security Act the information provided to consumers and consumer choice with respect to the plans is really a critically important dimension. Your comments about people speaking with their feet in terms of moving toward managed-care plans, much of that, as you know, has been driven by the private sector and by the employers like Xerox who have done, I think, an outstanding job in identifying quality plans and assuring that their employees had the option of choosing those and providing them with information about those in order to make that choice.

I just wanted to say a couple more things, one about the denial of services and benefits. This has been a problem, of course, in the fee-for-service insurance plans for years. Many of them have medical boards that review those denials, but it is a potential problem in both fee-for-service and managed care, and we need to be very alert to that in both types of plans.

Mrs. JOHNSON. Actually, it has been an enormous problem in Medicare. The denial has often been used as a budget control

mechanism. We went through a period in my office specifically where we won every single Medicare denial that we helped our constituents to appeal because they had no validity, but it was a budget control mechanism. But to get back to your consumer information, because this is key, between Mr. Vladeck's last statement and really what underlies this hearing, we are not prepared yet to give the consumers the information they are going to need to judge the quality of a plan or all of the things we tell them they ought to be able to judge, so I think we ought to be just up front with them about that, that we are really several years off from being able to do this.

We hope to be able to do it. We are not sure we are going to be able to do it, but we do think we can at least be helpful, but I think that is important because we are misleading people to some extent on that score.

At any rate, certainly good information is going to take time to develop, and this hearing does demonstrate how far behind the private sector we have been in even identifying the questions.

I would tell you also that I recently was at a seminar on estimating the cost of any health care reform plan, and we are on solid ground in estimating about the first 15 percent through the model and after that it appears to be all guesswork if you look at the research done over the last 20 years, so the public ought to be well aware that our vision is far more developed than are our means or really our knowledge level, and it is one of the reasons why a lot of us are reluctant to make as radical a change as others may want. Thank you.

Chairman STARK. Thank the gentlelady.

Mr. Levin.

Mr. LEVIN. Thank you and welcome. Let me just ask you a couple of quick questions. I will try to stay within the 5 minutes.

How much do you think reform should tilt incentives toward HMOs over fee-for-service? Given your long experience, just tell me roughly how much of a tilt there should be.

Mr. VLADECK. I don't think it should tilt at all. I think the difficulty, and we will need to continue to work with you, is to make sure, given the differences in characteristics between plans—to reuse the cliché—that it really is a level playing field in terms of the way prices are determined, in terms of the way copayments and out-of-pocket liabilities are determined, in terms of the way consumers get information, get into the system and so forth. There are a lot, as you know, of assertions made about one form of organization being inherently superior to the other, and we really think if we believe in consumer choice, then we have to give people fair choices. And we have never seen a situation in which they have had truly wide open choice in that regard.

Dr. LEE. I think also when you capitate both systems, you can pay the providers—the physicians—for example, in a plan on a fee-for-service basis. In a staff or group model, they will be on a salary basis. And those plans currently are competing, when you have an indemnity-type plan, with open-ended fee-for-service.

Increasingly, at least it appears in California with the CALPERS experience, that those indemnity plans are not able to compete with providing a standard benefit package and an equivalent cost-

sharing arrangement. So it would appear that the managed-care plans are able to meet those requirements. They have quality standards. They have standard benefit, and the indemnity fee-for-service plans have not been able to, in terms of meeting the required price requirements under CALPERS, but—

Mr. LEVIN. You don't disagree with the basic premise that Dr. Vladeck has just stated?

Dr. LEE. Absolutely not. There should be no tilt in one direction or another.

Mr. LEVIN. So any difference in copayments should reflect real differences in costs and not incentives to move into one or the other?

Dr. LEE. I would agree with that.

Mr. LEVIN. I think you find some interesting contradictions. People who say they are for choice often really are in favor of a tilted playing field. But I, for one, very much agree with the statement that we should not have a built in tilt. The choice should be real. And I might point out, as the GAO is going to testify, when you provide HMO enrollees with the option to go outside of the HMO, very substantial numbers of persons will do so—going outside of the restricted choice. On page 6, they say more than a third have claimed dollars paid for care delivered by nonnetwork providers in PPO and point-of-service plans. So I think we need to be careful that we don't tilt the playing field and that we keep real choice.

Let me just, then, ask you, so I can conclude, the orange light is on. The GAO's forthcoming testimony is based on some older studies. Do either of you have any basic criticism of the GAO study or conclusions?

Mr. VLADECK. I am afraid I haven't seen it yet.

Dr. LEE. I haven't read it, but I have got a summary of it, but I would say we would need to review it carefully and comment on it after we have had opportunity to review it.

Mr. LEVIN. Would you do that, because it states the evidence is inconclusive as to the extent to which managed-care plans hold down employer costs. And on page 7, they summarize a lot of other data. For example, patients reported similar levels of satisfaction with hospital care, but lower overall satisfaction with physician care in prepaid plans. These findings will be used by a number of people, including myself, as reasons for making certain that we have real choice.

Unfortunately, I have to leave for a while, so I will miss some of the discussion with GAO. But I would appreciate it if the two of you could comment on it. We often do these things seriatim, you know, and rarely have real dialog between witnesses. So if you would give us the benefit of your critique of the GAO's testimony and the CBO's study, it would be helpful.

Thanks as always for your incisive and insightful comments. Thank you.

Chairman STARK. I am amazed. This study was completed and released some time ago. Did GAO contact you at all about managed health care?

Mr. VLADECK. We may be getting studies confused. I understood the GAO was testifying today to a study that has been in draft form that we haven't seen a final copy of.

Chairman STARK. In October 1993 they did a study, "Managed Health Care Effect on Employers' Costs Are Difficult to Measure," October 1993.

Mr. VLADECK. That one we are familiar with.

Chairman STARK. You would have seen that. I think that is what the gentleman from Michigan had in mind. Would you care to comment?

Mr. LEVIN. Today's testimony reflects that.

Mr. VLADECK. I think the GAO study points up exactly the issue that in the private sector, as well as in the public sector, our mechanisms for paying managed-care plans and for adjusting for risk in the management of a multiple choice plan are still sufficiently embryonic, so you can't be sure you are going to save money.

Chairman STARK. Let me try this because I know that neither one of you wrote this deathless prose that was presented today, but on page 5 of it there is a statement that managed care saves money through lower premium growth.

Now, CBO has indicated quite to the contrary that although some staff and group models may, there is no evidence of savings in rates of growth. But you suggest on page 6 that recent trends suggest there is evidence. What evidence do you have?

Dr. LEE. We had a review, Mr. Chairman, by Hal Luft at UCSF, and Bob Miller, both economists, and we will be glad to provide that report for the committee.

Chairman STARK. This is a review?

Dr. LEE. Yes, they have done a literature review since 1980, and in that analysis they did state, and I have summarized that in my statement, and there has also been—

Chairman STARK. That was evidence, you say, of slower growth?

Dr. LEE. It is published work from the literature.

Chairman STARK. I am talking about evidence that this is a slower rate of growth. This isn't speculation?

Dr. LEE. No, this is not speculation. This is based on their analysis and Hal Luft is one of the leading—

Chairman STARK. I understand that. It has numbers attached to it?

Dr. LEE. Yes. There is a second study that was the Kaiser Family Foundation funded by Tillmann, Bagby and Garrett.

Chairman STARK. We will hear about that later.

Dr. LEE. We will also provide that.

[The studies are being retained in the committee files.]

Chairman STARK. They will be here to testify exactly how much. Then you referenced CALPERS as evidence.

Dr. LEE. Right.

Chairman STARK. Now, you are aware that the reason and the only reason that CALPERS was able to hold those premiums down is that there were reduced benefits to the beneficiaries, do you not? That is stated by Kaiser and the others who reduced them.

Dr. LEE. Well, what CALPERS did was require a standard benefit.

Chairman STARK. No, that was after the reduction you are talking about and the plans in CALPERS stated, and we have that if you would like to see our evidence, that the only way they held the

premiums down was to reduce benefits to beneficiaries. That is something I don't think the administration wants to be identified with, do they?

Dr. LEE. Well, it is my understanding that CALPERS—Kaiser had to raise its cost sharing.

Chairman STARK. You don't think that is a reduction of benefits.

Dr. LEE. And they lowered cost sharing in other plans. So that it is my understanding that in CALPERS, and we really need to speak with them directly, there was less cost sharing in the aggregate than there had been before.

Chairman STARK. But Kaiser will tell you that the only way—

Dr. LEE. Kaiser had to raise their cost sharing, but there was a standard benefit required of all the plans.

Chairman STARK. That was subsequent to that. I just would suggest that when you make statements about evidence of rates of growth and particularly in contravention to the CBO or, GAO that will provide us with a fairly thorough review, or GAO, that there is a bit of sloppiness in this testimony in terms of providing backup details. I suggest that where you mention evidence several times, and I won't go through each place, that it would be of some help to the committee if that evidence exists.

Dr. LEE. We will provide that to the committee, Mr. Chairman, promptly.

Chairman STARK. Each time in the testimony where it says evidence, it would be interesting to have a copy of that.

Dr. LEE. We will provide it.

[The following was subsequently received:]

In each instance in which we have used the word "evidence," we would cite evidence from the two studies discussed above—the study by Miller and Luft, and the study by Tillmann, Bagby, and Garrett.

Chairman STARK. Bruce, just one other thing. I do agree with you that the Medicaid program hasn't met the needs of low income, but again, is there any evidence that the problem is fee-for-service medicine, which certainly is working well in the Medicare program, and the one most recent case is the trouble we are having now in Tennessee. They can't get physicians to join the TennCare networks. Isn't that evidence that there could be some major problems with managed care providing care to the poor, for which we don't have an answer.

I mean, I am not suggesting there is a right answer and a wrong answer, but I am deeply concerned that we don't, quote, "have any evidence that these programs are panaceas."

Mr. VLADECK. Well, again, we try to be clear that they weren't panaceas, and I think it is really very early to tell. TennCare has been in place for 33 days, and it is probably a little early to draw a definitive conclusion about it.

Chairman STARK. But one of the things that you could suggest about it is that first of all it launched without having adequate planning. It made statements about having physicians signed up without checking with the physicians, which is a common courtesy, it would seem to me, some of whom I understand were dead. That is an interesting provider list. In other words, what it might show us or what we might learn from it is that before we allow these new programs to take over the care of the most fragile members

of our society that we are a little better prepared with adequate regulations.

That means resisting tremendous political pressure, I understand that, but that maybe is what we have to do or we will have more kids die because they can't find a doctor, and that is—

Mr. VLADECK. Let me just speak a little bit from my personal experience where I know firsthand the community better. In New York there were a number of areas in the City of New York where regardless of what one did to the Medicaid fee-for-service rates, one would never attract high quality providers. Since the development of Medicaid managed care, the opportunity, frankly, to create financial incentives for providers and managers under a capitated rate has really not only attracted new entrants, but has transformed the behavior of the existing hospitals and other large institutions and is really producing greater medical care than any—

Chairman STARK. We have the same thing in California. Community clinics have worked in Dr. Lee's old neighborhood and in my neighborhood. The minute we opened it up under Governor Wilson to allow Medi-Cal and turned it over to one of these managed care systems, they signed up people with promises and then kicked them all out of the community clinics and wouldn't fund visits to community clinics.

Now, that is wrong. That gets us one step forward and two steps backwards, and those are the concerns that we have to worry about. I am not sure we could write definitive rules, but it does argue, I feel, for a little bit more of a go-slow approach to completely revising the way health care is delivered, particularly when we don't have any experience. That is what troubles me.

We know what kind of people steal from us. We have developed overutilization screens and experts. I bet you have got 50 people in HCFA alone who are experts in overutilization. Is that a fair guess?

Mr. VLADECK. At most.

Chairman STARK. At most. Well, 20? How many do you have that are experts in underutilization?

Mr. VLADECK. Fewer.

Chairman STARK. Because it is an idea that we are not used to. Well, listen, I have beaten up on you. Unless you want to submit the new evidence for risk adjusters, which I notice were in your testimony, have you learned something since our last discussion in this committee, not with you, about risk adjustment that you would like to share with us? Has there been a new thesis? Is there risk adjustment?

Mr. VLADECK. There will be.

Chairman STARK. When?

Mr. VLADECK. As soon as possible.

Chairman STARK. When would you guess?

Mr. VLADECK. We will have some interim mechanisms within 12 to 13 months.

Chairman STARK. OK. Thank you both very much for your testimony. We will try to make the next encounter more detailed.

Dr. LEE. Mr. Chairman, in closing, I would just like to make one clarifying point with respect to the exchange that Mrs. Johnson and I had with respect to the practice guidelines. There is a dem-

onstration project authorized under the Health Security Act. It isn't a blanket provision because we haven't had enough experience to know whether that is a valid protection or not, but that demonstration would go forward.

Chairman STARK. Great. Thank you.

Chairman STARK. Our next witness is Mark Nadel, Associate Director for National and Public Health Issues for the General Accounting Office. He is accompanied by two of his associates from the GAO Human Resources Division, Michel Gutowski, who is Assistant Director, and John Dicken, who is evaluator, and Mr. Nadel and his colleagues and Mr. Ed Stropko, who is the Assistant Director for Health Financing and Policy. The GAO is here to present the results of a study they conducted on the extent to which managed care was saving money for employers, which I have had the privilege of reading and studying. And, Mr. Nadel, you may proceed to enlighten us any way you are comfortable.

STATEMENT OF MARK NADEL, ASSOCIATE DIRECTOR FOR NATIONAL AND PUBLIC HEALTH ISSUES, DIVISION OF HEALTH, EDUCATION AND HUMAN SERVICES, U.S. GENERAL ACCOUNTING OFFICE; ACCOMPANIED BY MICHAEL GUTOWSKI, ASSISTANT DIRECTOR, DIVISION OF HEALTH, EDUCATION AND HUMAN SERVICES, JOHN E. DICKEN, EVALUATOR, DIVISION OF HEALTH, EDUCATION AND HUMAN SERVICES AND ED STROPKO, ASSISTANT DIRECTOR FOR HEALTH FINANCING AND POLICY

Mr. NADEL. Thank you, Mr. Chairman. I am pleased to be here today to testify on our study of employers' experience with managed care. That study, as you mentioned, was released in October of 1993.

First, let me clarify what we mean by managed care, a term that really doesn't have a commonly accepted definition. In a sense, almost all insurance plans have some managed care because they all use utilization review, prior approval for hospitalization, and so on, which are also common to managed care.

As we use it in our report, however, managed care refers to plans that constrain patients' choice of providers to a specific network of physicians and hospitals, control the use of services, and negotiate reimbursement with providers. So defined, about half of all insured employees are now covered by managed-care plans.

In brief, we found that certain managed-care plans by negotiating physician and hospital payments and controlling the use of services have a potential for holding down costs. Lower costs for these plans, however, do not necessarily translate into lower health care spending in the aggregate for employers. In addition, we found that employees like some features of managed-care plans, but do not like limitations in their choice of doctors.

Let me turn now to the issue of cost. The potential for managed-care plans to save money depends on the stringency of several control features. The more that the plans limit or provide incentives for enrollees to use doctors in the network, the greater a plan's potential for controlling costs. Also, plans have more—

Chairman STARK. Say that again, just that sentence.

Mr. NADEL. OK. The more that the plans limit enrollees' choice or provide incentives for enrollees to use only doctors in a particular network, the greater is the potential for controlling costs. Also, plans will have more leverage to bargain on fees with providers if they provide a substantial share of the providers' total patient load.

Studies have shown that health maintenance organizations have the greatest potential for savings of all managed-care types. HMOs generally provide care only by their affiliated doctors and use a gatekeeper for referral to specialists and to hospitals. They are paid a set amount per patient and typically pay doctors by salary or a fixed amount per enrollee.

Now, little research is available on the cost saving potential of other types of managed care, newer types of plans, such as independent practice HMOs, preferred provider organizations, and point-of-service plans. Consumers in many of these plans are allowed to seek care from physicians outside the plan network by paying a higher out-of-pocket cost.

As we show in the figure held by my colleague, John Dicken, the newer types of managed-care plans have grown significantly since the mid-1980s and now serve about 75 million enrollees. You will see the bottom darkest bar there is for traditional HMOs.

Chairman STARK. What is the middle one? I am having a little trouble reading.

Mr. NADEL. The middle is IPA network-based HMOs, and the top is PPOs. You see starting around 1985 the most rapid growth are in PPOs, preferred provider organizations. So in summary, then, the greatest growth has been in the newer forms.

Although many employers that we contacted believe that they are saving money from managed care, the evidence is inconclusive about whether they actually hold down employers' costs. Some employers have experienced one-time reductions in cost growth with managed care, but rapidly growing health care costs resumed in later years.

When managed care plan premiums have been consistently lower, savings are more likely the result of favorable selection. This occurs when plans serve younger, healthier enrollees, and who are, of course, less costly than would be served in the remaining plans of the employer, typically indemnity fee-for-service plans.

Evidence from recent surveys conducted by employer benefits consultants is also inconclusive. Some surveys indicate that premiums are lower for managed-care plans than for indemnity plans while other surveys contradict this. As we see in the next figure, the surveys also indicate that during the last 7 years managed care and indemnity plan premiums have had similar growth rates. The overall trend shows pretty similar tracking.

One thing we do find, of course, is HMO premiums have grown a little bit slower, but the growth rate in the last couple of years has been quite similar. In comparing managed care and indemnity plans, I want to emphasize, none of the recent surveys of employers' premiums have adjusted for differences in enrollee characteristics or benefits that are covered.

Even if some managed-care plans effectively lower the use of services, the plan savings may not be fully passed on to employers in lower premiums. Some plans use a practice known as shadow

pricing in which they set their premiums at a rate near employers' other health plans regardless of their actual costs.

Turning now to the impact on consumers, trends in enrollment in managed-care plans show that many employees prefer more flexibility in choosing providers than traditional HMOs offer, and they are willing to pay more out of pocket to do so.

In fact, in PPOs and point-of-service plans, more than a third of claims dollars paid is for care delivered by nonnetwork providers. In general, enrollees in managed-care plans are constrained in their choice of providers and in their access. New enrollees may lose continuity in their source of care because they may need to change providers if their current physicians are not in the new plan's network. Also, enrollees may have to change providers when changing jobs, when doctors leave the network or when the employer changes health plans.

Many employees enroll in managed care despite the limitations on choice of providers. When offered an option, about one-third of employees on average enroll in an HMO. These employees are willing to accept the restrictions on provider choice in exchange for reduced out-of-pocket costs and more extensive preventive care. HMOs generally require only minimal copayments and no deductibles.

Nearly all HMOs offer, for example, well baby care and adult physicals as compared to only one-third to one-half of indemnity plans. Although research is limited, we reviewed one major study of patient satisfaction comparing managed care in indemnity plans. It showed that overall patients receiving care from prepaid providers rated their care lower than patients visiting fee-for-service providers.

Patients reported similar levels of satisfaction with hospital care, but lower overall satisfaction with physician care in prepaid plans. Specifically, patients rated primary care physicians in prepaid plans lower in availability, continuity and treatment manner, but higher in affordability and coordination of care.

In conclusion, managed-care arrangements are dynamic. They are undergoing changes as enrollment expands. Frequent changes in an employer's managed-care plans and the evolving managed care market have made assessing plan effectiveness very difficult. Ultimately, performance measures need to be developed that will allow employers to make informed decisions about health care plans and providers.

Recognizing this growing trend in the market, many reform proposals call for expanded efforts in data collection, quality measurement, and risk measurement.

This concludes my statement, Mr. Chairman. I would be happy to answer any questions.

[The prepared statement follows:]

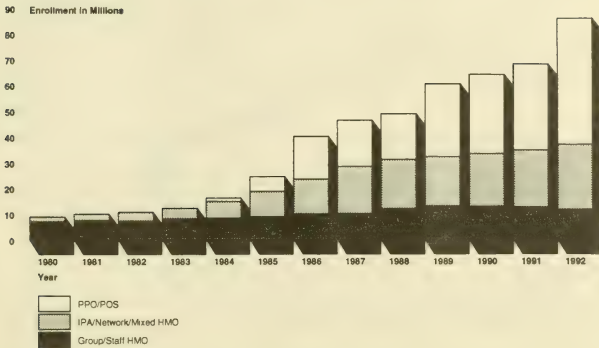
**TESTIMONY OF MARK V. NADEL, ASSOCIATE DIRECTOR
NATIONAL AND PUBLIC HEALTH ISSUES
HEALTH, EDUCATION, AND HUMAN SERVICES
U.S. GENERAL ACCOUNTING OFFICE**

The term "managed care" lacks a commonly accepted definition. It has been used to characterize a wide range of health care plans that select a network of physicians and hospitals, negotiate reimbursement levels, and apply controls on the use of services. The spectrum of such plans ranges from simple preferred provider networks to more tightly structured health maintenance organizations (HMOs).

This statement presents the results of GAO's review of employers' experience with managed care.¹ We found the following:

- o Certain managed care plans have a potential for providing care at lower cost. Their ability to do so depends on the stringency of controls on price and the use of services. The extent of incentives for consumers and providers determines the degree of leverage in controlling costs.
- o Little empirical evidence exists that employers' overall health care costs have been constrained by using managed care plans. In some cases, after an initial slowing, rapid cost growth continued in subsequent years. In other cases, savings from managed care plans resulted from those plans primarily serving healthier employees. Even then, pricing policies may not have fully passed savings on to employers.
- o A major constraint on consumers of managed care is their more limited choice of physicians. To gain greater employee acceptance, employers are offering newer types of managed care plans with more flexibility but less cost-saving potential. Today, more than half of managed care enrollees are in preferred provider and point-of-service plans.

¹Managed Health Care: Effect on Employers' Costs Difficult to Measure (GAO/HRD-94-3, Oct. 19, 1993).

Figure 1: Managed Care Enrollment, 1980-1992

Note: HMO data include Medicare and Medicaid enrollees.

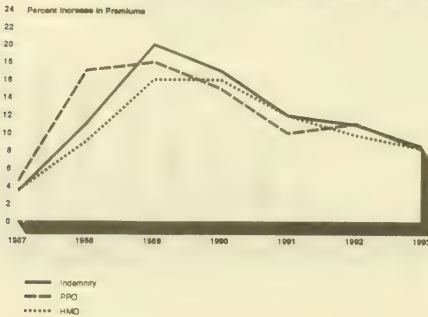
Source: GAO estimates based on data from Interstudy, KPMG Peat Marwick, and Health Insurance Association of America.

Effect on Employers' Costs Difficult to Measure

Although many employers that we contacted believe that they are saving money from managed care, the evidence is inconclusive about the extent to which such plans hold down employers' costs. Some employers have experienced one-time reductions in cost growth with managed care, but rapidly growing health care costs resumed in subsequent years. When managed care plan premiums have been consistently lower, savings are more likely the result of "favorable selection." This occurs when plans serve younger, healthier, and less costly enrollees while leaving more costly people in the employers' fee-for-service indemnity plans. Favorable selection could result from the reluctance of persons receiving regular medical care to change doctors to join a managed care plan and managed care's emphasis on preventive care services.

Evidence from recent surveys conducted by employer benefits consultants is also inconclusive. Some surveys indicate that premiums are lower for managed care plans than for indemnity plans, while other surveys contradict this. A Foster Higgins' survey reveals that, for 1992, managed care premiums averaged 9 to 19 percent lower than indemnity plans. By contrast, Peat Marwick's survey found that, for 1993, managed care premiums were as much as 20 percent higher than indemnity plans. As shown in figure 2, the surveys also indicate that, during the last 7 years, managed care and indemnity plan premiums have had similar growth rates, while for most years HMO premiums grew slightly slower than indemnity plan premiums. In comparing managed care and indemnity plans, none of the recent surveys of employers' premiums adjusted for differences in enrollee characteristics or benefits covered.

Figure 2: Growth in Health Plan Premiums, 1987-1993



Sources: Health Insurance Association of America, 1987 to 1990; Peat Marwick, 1991 to 1993

Even if some managed care plans effectively lower the use of services, the plans' savings may not be fully passed on to employers in lower premiums. Some plans use a practice known as "shadow pricing" in which they set their premiums at a rate near employers' other health plans, regardless of actual costs. Shadow pricing may enable the plan to benefit enrollees, rather than employers, by passing savings on through expanded coverage or reduced out-of-pocket costs.

Consumers Concerned by Constraints on Choice of Provider

Trends in enrollment in managed care plans show that many employees prefer more flexibility in choosing providers than traditional HMOs offer, and they are willing to pay additional out-of-pocket costs to do so. In fact, in preferred provider organizations and point-of-service plans, more than a third of claims dollars paid is for care delivered by non-network providers.

In general, enrollees in managed care plans are constrained in their choice of providers and access. New enrollees may lose continuity in their source of care because they may need to change providers if their current physicians are not in the plan's network. Also, enrollees may have to change providers when changing jobs, when doctors leave the network, or when the employer changes health plans. Enrollees also pay more to visit physicians outside the network because managed care plans provide lower or no coverage for self-referrals to specialists, requiring patients to first obtain authorization from a primary care physician or the plan.

Many employees enroll in managed care despite the limitations on choice and access to providers. When offered an option, about one-third of employees, on average, enroll in an HMO. These employees are willing to accept the restrictions on provider choice in exchange for reduced out-of-pocket costs and more extensive preventive care. HMOs generally require only minimal copayments and no deductibles. Nearly all HMOs offer well baby care and adult physicals, for example, as compared to one-third to one-half of indemnity plans.

Although research is limited, we reviewed one major study² comparing patient satisfaction with managed care and indemnity plans. It showed that, overall, patients receiving care from prepaid providers rated their care lower than patients visiting fee-for-service providers. Patients reported similar levels of satisfaction with hospital care but lower overall satisfaction with physician care in prepaid plans. Specifically, patients rated primary care physicians in prepaid plans lower in availability, continuity, and treatment manner but higher in affordability and coordination of care.

Employers Adding Quality Monitoring to Managed Care Efforts

Managed care arrangements are dynamic, undergoing changes as enrollment expands. Frequent changes in employers' managed care plans and the evolving managed care market have made assessing plan effectiveness difficult. Because little empirical evidence exists on the cost savings of managed care, employers are increasingly focusing on strategies to improve their ability to assess plans. They want reliable data on costs, outcomes, and consumer satisfaction so they can make meaningful evaluations. Ultimately, performance measures need to be developed that will allow employers to make informed decisions about health care plans and providers. Recognizing this growing trend in the market, many reform proposals call for expanded efforts in data collection, quality measurement, and risk measurement.

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Mr. Chairman, this concludes my statement. I would be happy to answer any questions.

²The Medical Outcomes Study covered over 17,000 patients and adjusted for population differences. See Haya R. Rubin et al., "Patients' Ratings of Outpatient Visits in Different Practice Settings: Results from the Medical Outcomes Study," Journal of the American Medical Association, Vol. 270, No. 7 (1993), pp. 835-840.

Chairman STARK. Thank you. You conclude that there is no evidence to support the contention that managed care is saving money for employers. Does that suggest that if we are serious about slowing the growth in health care costs we should just cross our fingers and rely on the trends toward more managed care, or would you say that that is not enough to get your colleagues in the Congressional Budget Office to score some savings?

Mr. NADEL. We have very little influence over our colleagues in the Congressional Budget Office, but clearly under current plans it probably is not enough. But I want to emphasize that when we say that the evidence is inconclusive, we are certainly not saying that it can't be done or that managed-care plans are not saving money. The evidence is inconclusive one way or the other.

Second, it really is a dynamic market and employers are struggling mightily to hold down costs, and as plans evolve there could be greater potential.

Finally, it is really impossible to say what would happen under various reform proposals. For example, under managed competition, if, in fact, you really do get competing plans of various types and very hard bargaining, it may well be that costs would go down and those costs would, in fact, be passed on to employers and employees.

Chairman STARK. Let me go back to another issue some time earlier when you prepared reports for us on the problems with Medicare HMOs in Florida. Could you think back as to what your findings were and kind of summarize those for us and tell me whether you have any idea whether those problems have been resolved or if we have just been lucky since the last outbreak?

Mr. NADEL. I would like my colleague, Mr. Stropko, to address that issue since he did a lot of that work.

Mr. STROPKO. I think Dr. Vladeck went over many of the difficulties, and they are still persisting today.

Chairman STARK. They are still persisting.

Mr. STROPKO. I think so, as reflected in the Sun Sentinel article, through probably not to the same degree. I think they have done an awful lot since 1990.

Chairman STARK. We had one very bad apple, a guy who left the country and is still a fugitive, I believe.

Mr. STROPKO. They found him. He is in Spain.

Chairman STARK. Oh, they got him. Hasta la vista.

Mr. STROPKO. The problems generally center around marketing, failure to adhere to the grievance process. Medicare has a wonderful grievance process. It works pretty much automatically if the HMOs do what they are supposed to do to give people the rights they are entitled to, but the HMOs very often don't comply.

Chairman STARK. What you are suggesting is that our grievance proposals are good if we make sure they are adhered to?

Mr. STROPKO. I think so. Basically when a person has a complaint, they write a letter. Everything else is automatic from that point on. If they are denied, HCFA is supposed to look at that denial and make a decision whether that is appropriate. Oftentimes, they don't go through the whole chain, and they stop at HMO, the HMO denies, and it never moves forward.

Chairman STARK. In other words, they go to the fox and the fox says I didn't eat any chickens, and they don't ask why he has feathers all around the corner of his mouth.

Mr. STROPKO. That is basically it. Claims payment problems seem to be persisting where HMOs usually pass a lot of risk on. Some of the HMOs in that market pass a lot of risk on to affiliated providers which are basically clinics, individual doctors, who share a lot of the risk.

If they make a referral in some of those HMOs, that comes directly out of the doctor's pocket, that referral.

Chairman STARK. Is that legal under our risk contracting rule? One of the things we talked about earlier is when you have a contract with a doc where the incentives are built in, you know, just like selling Mary Kay Cosmetics, the less you do, the more you make. It seems that is not so good for the beneficiaries, and I thought we were supposed to have rules that prescribed, you know, what kind of profit sharing doctors can participate in.

Mr. STROPKO. I think they came out about 1988, but I don't think the regulations are yet finalized.

Chairman STARK. Do you think they are necessary?

Mr. STROPKO. You betcha. I don't know what the cut off is, but at some point when you pass too much risk to an individual doctor or a small clinic that is not funded to accommodate that risk, you are taking great chances that there is going to be underservice.

I don't like to depend on my doctor to give me a \$500 check to get an MRI, but that is essentially what some of these risk-sharing arrangements are doing.

Chairman STARK. If the doctor prescribes something and he is up to his limit with you, he pays for it in effect by reduced fees or out of his own pocket?

Mr. STROPKO. If the risk-sharing arrangement is that rigorous. I don't think there are any of them quite that rigorous. The most risk I have seen passed off is 50/50. They share 50 percent of the profits, 50 percent of the losses.

Chairman STARK. So I am an internist, and I decide really that you ought to have a heart transplant, but I know deep in my heart that that is going to cost, or even a valve operation, that is going to cost \$20,000. What you are telling me is \$10,000 of that comes out of my pocket?

Mr. STROPKO. They set up risk-sharing pools, and whoever your patients are in that pool basically constitute the pool of money that you share. So it wouldn't be necessarily one patient, but one patient can break your budget in that kind of a circumstance. It might be as few as 100 patients or a thousand patients, and there is some number beyond which you don't want to go.

I mean, HMOs have to have at least 5,000 members, right?

Chairman STARK. Is this covered in these potential rule makings that HCFA is sitting on, do you know?

Mr. STROPKO. I haven't looked at it.

Chairman STARK. But they would be worthwhile, you think, getting those into final form?

Mr. STROPKO. Most certainly, yes.

Chairman STARK. OK. Thank you. One other question to Mr. Nadel.

We are going to hear a later witness suggest that HMOs charge providers, hospitals and doctors kind of a 12 to 18 percent administrative fee, and then, of course, they have their own overhead operations, so if their overhead runs on a good day 10, 12 percent, the aggregate what they charge the provider, plus what they have for operating their own operation could run 25 to 30 percent.

Now, I brag, I understand that Kaiser Permanente where it is all in-house, can hold theirs almost as low as Medicare, that they are down around 5 to 8 percent, but do those numbers jibe with your findings that some of these managed-care operations can both have actual overhead and what they load on to their providers that could aggregate as high as 30 percent?

Mr. NADEL. We didn't look at the administrative cost component in this study of the plans. We did look at some data that Lewin had, and their findings were that you find the greatest administrative costs in the looser kinds of arrangements, particularly PPOs where the doctors will belong to a variety of plans, six, seven, eight plans, and that means they have to hassle with different forms. There are different forms from different plans, different copays, different referral protocols and so on, and that adds to a major hassle factor for the doctors as well as a major administrative cost.

In terms of actually getting inside the plans and looking at the administrative cost of the insurers themselves on the varying kinds of arrangements, we didn't get to that. But I think you are quite right with regard to HMOs. When it is all in-house as with Kaiser, they will have lower administrative costs.

Chairman STARK. Thank you very much.

Mr. Thomas.

Mr. THOMAS. Thank you, Mr. Chairman. I am sorry you took down the chart that you have from page 3 in your testimony.

Mr. NADEL. Would you like it back up?

Mr. THOMAS. Yes, I just think from a visual perspective it helps because in response to the chairman's question, you just indicated that it appears that PPOs have a higher administrative cost, although your study didn't focus on that.

I think from a logical point of view if you are going through six or eight different structures, the cumulative is going to be greater than the doctor who is an employee and you are dealing with it, that is common sense.

Mr. NADEL. Is that the chart that you want?

Mr. THOMAS. Yes. Yet clearly from the trend in the mid-1980s to current, the direction is toward PPOs and maybe in the trade off of cost reduction versus choice and quality, people are making a decision that this is a better balance between those than the other approaches. Is that a fair statement to make of your study? Can you make that statement of your study?

Mr. NADEL. Let me say one thing about administrative costs. In some cases, as we have said with Medicare, you have to spend money to save money. So there clearly is some trade off in that if you have no administrative costs, you have no controls, the sky is the limit. None of us would want that, so you are right, there clearly is some trade off.

In terms of looking at the overall growth there, what I have just said is that a lot of the administrative costs seems to be levied on

the providers. The plans are put together by the insurers, and there has been a lot of marketing of plans. It is hard to say that the growing popularity of those plans means that the administrative costs are not important or not—

Mr. THOMAS. Then let's disregard the color gradations in the last line, for example, is that 1992, I guess?

Mr. NADEL. Right.

Mr. THOMAS. And just compare the size of the graph, the number of enrolled with those back in the early 1980s, regardless of the mix, just the volume. Did your study, or the statement that you just made, show that in its marketing it probably shifted to PPOs or don't you know? It is inconclusive as to why it was done?

Mr. NADEL. I think it is inconclusive.

Mr. THOMAS. What about the total number? I mean, there is something going on there. Is that marketing, as well, that they have been able to elevate that many people into a structure by the marketing techniques?

Mr. NADEL. No. I think that employers are really sincerely trying to get a handle on costs, and increasingly they are looking at medical costs the way they have always looked at other costs.

Mr. THOMAS. Do they believe this is a way they can get a handle on costs, given the chart?

Mr. NADEL. Oh, yes. Most of them do, but at the same time, the fact that you have had so many changes in the market indicate that they are not quite satisfied, and don't feel that this is the magic bullet.

Mr. THOMAS. I think they will continue to be churning, but clearly the direction is upward toward some of these newer structures.

Mr. NADEL. That is right.

Mr. THOMAS. My understanding is that the study you did wasn't really the primary study, it was basically a secondary study. You were looking at other programs, other research in the area?

Mr. NADEL. It was both. We did talk to about 60 employers and a number of trade associations. Because we were unable to really get conclusive data that way, we reviewed the existing literature as well and presented that.

Mr. THOMAS. Did you do any evaluation of the methodology of the existing literature or basically they are reputable groups so you adopted it. Did you incorporate it in or did you determine whether or not the pattern is the same? I mean, how do you evaluate secondary sources as to whether or not you are going to fold them into your primary stuff?

Mr. NADEL. Well, it is not a matter of folding them in. I think we just presented their findings. You are right, no, we did not evaluate their methodology, but—

Mr. THOMAS. My second concern is that one of the things that is going on besides this trend toward new delivery structures for cost reduction is that the mix of the package available to the employee, or what the employee can do for their health care dollars, is changing as well. You examined the cost to the employer. What about the benefit package to the employee? That is, the cost may remain the same, but the employee might see what they perceived to be an enhanced benefit package for the same amount of money,

so that the employee-employer satisfaction index would go up, but the costs wouldn't necessarily go down.

Did you see any of that in your study or did you look at it?

Mr. NADEL. Yes, we did. Frequently, the benefit mix in an HMO will be richer in the sense that there is no deductible and usually lower copayments, so there was that. And also in the one study I mentioned in terms of patient satisfaction, the element that people are most satisfied with is in the cost area.

Mr. THOMAS. Well, since most of these or, I assume, a large portion of these are basically collective bargaining structures between employer and employee, and over the last 20 years given the tax benefit of negotiating fringe benefits, I think it is pretty tough to say that there have been no savings on the part of these plans if, in fact, the plans are richer in the eyes of the employer and the employee and that the employee isn't pushing for more, but believe they are getting more by a structure change to then jump to the conclusion that there is no savings.

Had they not gone to this structure, the employees would have put greater pressure on the employer to get more out of the plan, but in fact by changing structure, they have, so I don't see how you can make a statement that there isn't quote, unquote, "cost savings" unless the cost savings comparison is only that in 1985 the employer paid x dollars for it and in 1992 the employer paid x dollars, and there doesn't seem to be much difference.

Clearly, there is something going on under those 2 dollar numbers that perhaps your study didn't focus on or wasn't part of it to give you a much clearer picture of what is going on in terms of benefits perceived for dollars spent. So how much value is this study in terms of understanding the relationship between employee-employer value of health care services and cost to the employer?

Mr. NADEL. What we are saying is that the evidence is inconclusive that there are savings to the employer in the aggregate. We are not—

Mr. THOMAS. Did you compare the benefit package change during that same year of growth?

Mr. NADEL. Well, not in every single plan, but if the benefit package is getting richer, that is one of the elements of shadow pricing in HMOs; that is, the HMO costs could be lower, but they are, in fact, offering a richer benefit to employees. That is great for the employees, but the employer, then, is not realizing the full savings.

If the benefit package was actuarially equivalent, the employer might save more, so in that sense, sure, we certainly did look at the value of the benefit package.

A second point is we are not in any way denying or saying it is inconclusive that in many cases premiums are lower in HMOs, but what typically is not controlled for and what we think happens is that younger, healthier employees will opt for the HMO benefit. They like things like well baby care. They like the emphasis on preventive care. They aren't sick so they don't have really important ongoing relationships with their doctors, but the people who are older and sicker will tend to stay in the indemnity plan.

Mr. THOMAS. Does the study show that?

Mr. NADEL. Yes.

Mr. THOMAS. Mr. Nadel, what I am interested in is what is out there from your studies, not what you folks think. My concern is that we take a GAO study which is studying price only, and it seems to me that we have got some limits on methodology, perhaps some in structure on gathering information or even having it available, but I think it is safest to say, and you have repeated it several times, and I agree with you, that basically this study is kind of inconclusive. Either it isn't broad enough, it doesn't compare enough parameters, we just don't know, and that the last thing we should say of this study is that managed care doesn't save money.

Mr. NADEL. That is a fair statement.

Mr. THOMAS. It is also not fair to say that it does save money.

Mr. NADEL. That is true.

Mr. THOMAS. So here we go again with a GAO study in terms of trying to figure out just how much help it is. For example, the chairman mentioned the Florida study.

I would have loved to have seen in the Florida study a clear nail in the coffin that if, in fact, MRIs were used, the total billed to the patient was higher, and there was no improved health care of the patient, but what I got from folks who had studied it, was that they didn't look at that end of it to see if, in fact, there was a benefit by using MRI, either in terms of the quality of care or perhaps a reduction in costs by a choice made that wouldn't have been made if the MRI was used. So what I really am fearful of are these kinds of presentations which, as soon as we leave this room, it is going to be stated that the GAO says that there is no savings in a managed-care program. And I do want to underscore the statement that you used, the word that you used, it is inconclusive in part because of the methodology and the approach.

My problem is that when I look at that chart, something is going on. I don't believe it is clever marketing on the part of insurance agents. Somebody thinks they are getting value for money by changing the structure.

What I would very much like to see is a clear study to determine why, and you are more than willing to state that this one isn't it; is that correct?

Mr. NADEL. Is dead?

Mr. THOMAS. It isn't it.

Mr. NADEL. I am sorry.

Mr. THOMAS. It isn't able to explain why employers are showing this kind of behavior, or employees in terms of options, so my problem is I don't know what I would do with this study, like most GAO studies.

Thank you very much.

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON. On page 4 of your testimony, Mr. Nadel, you say when managed-care plan premiums have been consistently lower, savings are more likely the result of favorable selection. On what data do you make that statement?

Mr. NADEL. There have been a number of previous studies of managed-care plans where the data has shown that when you do look at the savings, favorable selection explains a good part of them.

Mrs. JOHNSON. And how many studies and how many managed-care plans?

Mr. NADEL. Do you want to do that?

Mr. DICKEN. There was one recent study that was in the Journal of the American Medical Association last year and did find that there were significant differences between those that enroll in a prepaid, HMO-type plan compared to a fee-for-service plan. There have been other studies such as that.

Mrs. JOHNSON. Now, that is enrolled in a prepaid plan.

Mr. DICKEN. HMO.

Mrs. JOHNSON. Now, most of the ones in the white area and most of the ones in the gray area are not prepaid.

Mr. DICKEN. The white area would not be prepaid.

Mrs. JOHNSON. Well, and some of the gray area would not be prepaid.

Mr. DICKEN. Right.

Mrs. JOHNSON. There is good reason to believe that the data on prepaid would be different than the data on other managed-care systems, and I think that is supported by your own testimony that indicates that one-third of the bills are outside the network. People want flexibility, they want choice.

The people who care least about flexibility and choice are the young people without physician attachments, or without serious illnesses, so, of course, you might have selection in prepaid plans that wouldn't necessarily be consistent for all managed-care plans. So the reason I am raising the issue of the number of studies is that CBO based their study on one plan, one plan, and they drew conclusions for the Nation.

Now, when you make a statement like this, "are more likely the result of favorable selections," you are the GAO, now let's have some detailed, specific data. How many studies, how many instances, were they prepaid, were they not?

I mean, when you see a chart like that that shows all of America, and I represent a manufacturing district, we have had a hell of a time in the 1980s, machine tool companies, bearing companies going under, unfair trade practices, you name it, we have had it. They have begged me to do something to help them be more competitive, and number one was health care costs, and that was in 1982, 1983, 1984 and through this year.

We did competitive studies. We talked about tax changes that could help them. We talked about health care cost control that could help them, Congress did neither. They did it in the private sector, and see what they did. They walked with their feet. They voted.

What would control their costs, and even though that evidence is overwhelming and before you, your own administration testified, I mean, the administration testified that now all of the States have gone into managed care for Medicaid patients and everybody is moving more rapidly in that direction because they want to control costs.

And really what you have done here is to say we don't know because none of these studies was adjusted for enrollee characteristics. That is, are you young, and therefore do you want to take prepaid, or are you old and critically ill? Are you middle-aged with se-

vere diabetes? I agree with you that unless you have this information, you can't document it. My colleague made a very good point. Isn't it cost control if you are a company that is under collective bargaining and you want to control your health care costs and so instead of a higher premium you give a plan that offers more benefits?

Now, is the technology and the science and the intellectual level so low in health care that you can't do what we did in trade to help us at GATT get a square deal on trade policy? What they did at GATT was very simple. They translated national subsidies into tariffs. They tariffed subsidies and then harmonized the tariffs, but they made visible these things.

What your report is really saying is that we don't know. We can't make visible yet in the data and cost variations in benefits, so because we can't tell whether we are comparing apples and oranges, we are going to tell you there is no savings in managed care, and yet the practical, real world is telling you with every breath in their lungs that this works far better than fee-for-service, and the Government, which is miles behind the private sector, is still saying, well, gee, you didn't do the right studies 3 years ago.

That is true they didn't, and we need to do that, and I don't for a moment say that we don't need to do all the things in your testimony you say we need to do, but when you can't cite to me studies that are technically accurate or even relevant, and you admit yourself they are prepaid, come on! How can you possibly make the statement that it is going to more likely result in favorable selection except possibly for the prepaid plans.

So, your data in terms of benefits, you haven't looked carefully at, are they getting more in benefits? If you translate higher benefit plans into higher dollar costs, which we can do, in the private sector, what the premium value is of a plan that provides prescription drugs versus one that doesn't, so have you done any studies, can you cite any of your own work that has translated benefit expansion, dollarized it, premiumtized it, so you can say do these premiums now represent a savings?

You don't cite any of that material. In fact, you say specifically in comparing managed care and indemnity plans, "None of the recent surveys of employers' premiums—" and you don't offer any other information "adjusts for differences in enrollee characteristics or benefits covered," and if you can't answer that, you can't sit there and in good faith tell me that what the public has said controls costs or helps them with controlling costs doesn't work.

Mr. NADEL. Mrs. Johnson, the statement is based on our October report which has a substantial number of citations to the literature. I think—I know we looked at all the relevant recent literature on managed care. I am sorry I wasn't more clear. What we were saying is that it is inconclusive whether the existence of managed-care plans in an employer's portfolio of health care plans, lowers the employer's overall costs.

We do point out that there is evidence, and that there is conclusive evidence that staff and group model HMOs do have lower costs, but that is not where the growth is. The literature, Mrs. Johnson, is absolutely unanimous that it is inconclusive about the cost savings potential of a newer, looser form of managed care. You

have our report, and we will be happy to separately list for you all the studies which draw that conclusion.

We would not present this information if we couldn't stand behind it.

Mrs. JOHNSON. OK. Can you give me, then, an analysis of how many of those plans expanded benefits that didn't lower employer costs, but did expand benefits?

Mr. GUTOWSKI. I think that is one of the reasons we point out that there aren't savings to employers. It is one of the reasons, and we can't differentiate among the different reasons. That is, that there is a difference in benefit structure and a difference in benefits received.

Mrs. JOHNSON. Right, and you ought to have been able to do some analysis to show us if generally managed-care plans provide broader benefits, though a narrower network of care providers. If they do generally provide broader benefits, which has been my experience, then if you provide more for the same dollar, you are saving money.

Mr. NADEL. If you are providing more for the same dollar, and it is true, that in that sense you would be more cost-effective if you were doing so. The question that we were addressing is whether they reduced the employer's overall health care costs, and that is what is—

Mrs. JOHNSON. But the employer's health care costs would have gone up because he had to provide more and they kept it even, so it is just that really we have got to do better than this, to make national policy and to especially make national policy that interferes with the development of the very reorganization of the market that is the only reorganization we know will help. The only way you are going to reduce administrative costs is to better integrate the delivery of services, and it is the only way you are going to get professionals in closer communication to make better judgments about volume of services. And we know that, and that is why that chart says what it does.

And for Government, then, to be able to say nothing more than you say in this report and not even to have dollarized benefit expansions so that you could have said if they had expanded these benefits, it would have cost them this much more, you can make your own judgment as to whether they saved money or just avoided cost increases. It seems to me really inadequate given the importance of this issue in the national debate, when all of the public has one set of experiences, and you come out with something that basically says we don't know, we can't tell. All this is a review of the literature, and when you look behind the literature to the quality of the studies, the one you gave me, Mr. Dicken, and we don't have time to go into all the studies, but that one in itself demonstrates that you can't generalize from a study that is done on prepaid.

Mr. DICKEN. Let me just add—

Chairman STARK. I thank the gentlelady. I, too, like the idea that when I get a report I don't like, beat up on the person who wrote the report. That makes good sense to me.

The CBO, who is not right here to defend themselves, did respond to a complaint by Mr. Cooper. They said that while the var-

ious mechanisms such as utilization review and managed care can achieve a one-time drop in cost, there is little evidence that they reduce the subsequent rate of growth in cost. Because H.R. 5936—and this is entirely with reference to that—relied exclusively on such policies to control costs, CBO's estimate of the bill assumed no sustained reduction in the rate of growth of health spending, so their comments were limited to one particular bill.

Now, the Minority was asked to submit witnesses who could provide their evidence of cost saving, and we will hear later today from a prestigious firm that was hired by the managed-care folks to prove their case, they will testify about a Peat Marwick study that purports to show that there were lower spending and would make you look like a bunch of noodles, right?

So, Mr. Nadel, have you read the Peat Marwick study?

Mr. NADEL. Yes, I have, Mr. Stark.

Chairman STARK. How would you characterize it? I know you will be much more gentle than I will, but how would you characterize that study, and is it indeed without its flaws?

Mr. NADEL. Well, it is really similar to previous surveys that Peat Marwick and Foster Higgins had done that we relied on in that, again, it did not adjust for characteristics of employees, so it was purely addressing premiums. Our position is that the premiums alone only tell you part of the story because the people who are not in HMOs, and I believe they were specifically addressing HMOs in that study, may have worse health status. And so the premiums that have to cover them are covering a great deal more services.

Also, when you look at that study, you will see that they come up with somewhat different data for 1993 than we do, and the reason is that their latest study uses a different mix of size of firms than earlier data from Peat Marwick that we relied on in adding data for this testimony.

Chairman STARK. Is it not true that the Peat Marwick study very clearly in their own study shows that fee-for-service benefits increased substantially in that period while HMO benefits were reduced?

Mr. NADEL. That is right.

Chairman STARK. Somehow isn't there a logic that if you increase benefits a lot your costs go up, and if you reduce benefits your costs go down? Is that reasonable for a person with my limited ability to understand this stuff, but that is a reasonable assumption, isn't it?

Mr. NADEL. That is a very reasonable assumption, and that is an excellent point. When Dr. Lee and Dr. Vladeck testified, there was some discussion about CALPERS and the cost saving there. One reason that Kaiser was able to hold down its cost increase to CALPERS was that they raised the copayment. It is not huge, but as a percentage jump it was pretty significant.

At the same time, of course, you have a trend in indemnity plans to start offering more preventive services, so the spread in benefits is maybe narrowing a bit.

Chairman STARK. Well, I want to thank you very much.

Mrs. JOHNSON. Mr. Chairman.

Chairman STARK. Just for the record.

Mrs. JOHNSON. Just before you close out.

Chairman STARK. Would the record show, did any of you publish any studies on NAFTA?

Mr. NADEL. On NAFTA?

Chairman STARK. NAFTA.

Mr. NADEL. Not me personally, but GAO put out a study on NAFTA.

Chairman STARK. Did you support it or oppose it?

Mr. NADEL. That is beyond—I have trouble enough keeping up with health literature, Mr. Stark.

Chairman STARK. You didn't support or oppose it, is that correct, as an individual or your team?

Mr. NADEL. Our team neither supported nor opposed NAFTA, sir.

Chairman STARK. All right.

Mrs. Johnson.

Mrs. JOHNSON. Thank you, Mr. Chairman. My point in bringing up the trade area was simply that if we can translate, if we can monetarize subsidies into tariffs, then we ought to be able to deal with monetarizing benefits, so that we compare apples and apples and not apples and oranges.

I think that is still a legitimate point, and the fact that no effort has been made to do that, now, my understanding of what you just said is that the Peat Marwick survey and the Higgins Foster surveys were done on different sized companies?

Mr. NADEL. The Peat Marwick survey that you will be hearing about later today was done on different sized companies than an earlier Peat Marwick survey that we looked at that has somewhat different numbers and cost growth. It was also based on 1993 data, and we can provide more details on that for the record if you like.

Mrs. JOHNSON. Another significant variable that makes comparing the end figures difficult because we know the costs in different size sectors is quite variable for reasons other than care costs.

Mr. NADEL. That is right.

Mrs. JOHNSON. Also, might not the difference between the Foster Higgins figures and the Peat Marwick figures reflect some of the underwriting cycle issues that are a problem in the insuring industry since they are consecutive years?

Mr. NADEL. Well, that would be reflected really in the earlier chart we had about the various growth rates where you see a sort of a spike and then the growth rate will go down. That tends to be in inverse proportion to the underwriting cycle; you are correct.

Mrs. JOHNSON. Did you look at these two studies in light of that chart?

Mr. NADEL. I am not—

Mrs. JOHNSON. What percentage of the data that is reflected here or the price changes reflected here can be attributed to underwriting cycle issues?

Mr. NADEL. I think we are unable to determine that.

Mrs. JOHNSON. It seems to me very relevant, and it seems to me misleading to suggest that in 1993 indemnity premiums were 20 percent higher on average than in 1992 without considering the underwriting cycles, so I think the—

Chairman STARK. Is the gentlelady questioning what the premiums were?

Mrs. JOHNSON. No, I question what they reflect, the costs that they reflect, and I think when you see that chart you see the complexity of the whole ratesetting mechanism, and then to say juxtapose these 2-year studies and imply the conclusion is simplicity to the point of being misleading. I think it is also interesting that you say on page 5 that you need to adjust for characteristics and benefits covered.

You may also want to consider adjusting when you look at these studies and compare their outcomes with what group participates in each. Are you surveying small businesses or large businesses or a mix of them because the issues are different, so while it is easy to say that I am bashing you because I don't like the outcome, I am bashing this study because I think it begs the question.

It shows a chart like that, and then it makes statements like none of the studies were adjusted and makes no attempt to deal with even the simplest adjustment, which is benefit plan size, which we ought to be able to adjust for and try to get apples and apples adjacent to one another, so I hope that there will be more work in this area, and perhaps in the testimony following you we will certainly have some greater detail, but some of the studies have shown quite significant information. Whether it can be generalized over every plan or not I don't know.

I would also point out that in CALPERS that their premiums were halved. They didn't just drop, they were halved. Their HMO premiums went from 12.1 percent in 1992 to minus .4 percent in 1994 because for the first time, they were allowed to charge the same copayments as the nonHMO plans. Now, that tells you something. That is interesting information.

That suggests that managed care and copay together might make a lot of difference.

Chairman STARK. Excuse me. If you are a beneficiary and your premium was \$100 a month, and it drops to \$50, that is cut in half, correct?

Mrs. JOHNSON. Right.

Chairman STARK. Now, if your copays go up by \$100 a month, you are out of pocket \$50, aren't you?

Mrs. JOHNSON. Sure, but copays are far more minimal than that.

Chairman STARK. But that is what they did in CALPERS. They raised the copays more than they lowered the premium.

Mrs. JOHNSON. Well, I do not have the evidence to say yes or no to that, but I certainly would challenge you to bring that evidence, but in the experience-rated PPOs, they went in 1992 from a 9.5 percent premium down to a 7.9, the least dropped, and employee associations from 9 down to 5, so that the experience of CALPERS does suggest that between the integrated delivery system and patient participation, there is an impact on cost, and that is what we are trying to get at. So it may be that the specific instances will be more useful to us than the general research since it is a literature comparison behind which there is no consistency of example.

Mr. NADEL. Well, we did a report on CALPERS for this subcommittee which came out about 3 or 4 months ago, and in that one we did, of course, look at benefits.

The interesting thing about CALPERS is they had a period of very high growth which actually exceeded the private employers in California at a time when most of CALPERS was in managed care. It is true that they squeezed Kaiser down to zero growth in a recent year, but prior to the State fiscal crisis, the heavily managed-care CALPERS had pretty much the same premium growth, actually a higher premium growth than the rest of the State.

Mrs. JOHNSON. I think a lot of that had to do with benefit expansion, proceeding more rapidly than they had realized, so that is why, you see, if you don't look at benefits as well, what you are paying for, you can't look at cost control, so your report does recognize that and therefore is inconclusive in regard to the savings that managed care can offer us. And you have reiterated that a number of times, and I appreciate that honesty. Thank you.

Chairman STARK. I want to thank you very much. Look forward to working with you as we proceed through this legislative thicket. We will recess for 5 minutes after which we will hear the next panel of witnesses.

[Recess.]

Chairman STARK. Thank you for indulging the Chair.

We will continue now with our next panel of witnesses, and I heard some complaints from our guests about the acoustics in the room. The Chair will try to stop mumbling, and I will just try to be equally emotional on every statement, and therefore I will shout.

If I could exhort the witnesses to try to swallow those microphones as they talk with us, I think that will improve things. We are far from the 20th Century in electronics here.

I want to welcome Diane Rowland, who is the executive director of the Kaiser Commission on the Future of Medicaid, not to be confused with Kaiser Permanente Medical Plan, although it has the same genesis and the same attitude toward public service as the late Mr. Kaiser had intended; Susan Dooha, who is on behalf of the New Yorkers for Accessible Health Coverage; Michael Campbell, a staff attorney for the Pennsylvania Health Law Project, and he is accompanied by Ann Torregrossa, who is director of the Pennsylvania Health Law Project; and Lucy Johns, an independent consultant for Health Care Planning and Policy from the great State of California, more specifically, San Francisco.

Ms. Rowland, why don't you lead off. All of your statements, which are prepared, will appear in the record so if you would like to relate them to other testimony which you have heard or which you would like to hear, enlighten the committee in any way.

STATEMENT OF DIANE ROWLAND, SC.D., EXECUTIVE DIRECTOR, KAISER COMMISSION ON THE FUTURE OF MEDICAID, AND SENIOR VICE PRESIDENT, HENRY J. KAISER FAMILY FOUNDATION

Ms. ROWLAND. Good afternoon, Mr. Chairman. I am Diane Rowland, senior vice president of the Henry J. Kaiser Family Foundation, and executive director of the Kaiser Commission on the Fu-

ture of Medicaid. I appreciate the opportunity to share with you some of the commission's findings on Medicaid's role in serving low-income Americans and its experience with managed care.

Medicaid is today the Nation's major public financing program for providing health care coverage to low-income families and long-term care to low-income elderly and disabled people, serving 1 in 10 Americans and paying 12 cents of every \$1 spent on health care.

Medicaid serves nearly 30 million people and is the chief source of health insurance coverage for 22 million people in low income families. One in five American children receive their health care coverage through Medicaid.

In recent years States have embraced managed care as an overall health care access cost containment and quality improvement and budgeting strategy for the Medicaid population. I would like to set a few facts out for you with regard to this experience.

First, the growth in the number of Medicaid beneficiaries in managed care has been dramatic, rising from 750,000 beneficiaries in 1983 to 4.8 million persons today, 15 percent of the entire Medicaid population. However, it is important to note that the principal managed-care enrollees are Aid to Families with Dependent Children households, which are overwhelmingly comprised of low-income women of childbearing age and their dependent children. Managed care involves less than 1 percent of the disabled Medicaid population.

Second, managed care and Medicaid is not synonymous with HMOs. Only 41 percent of managed-care enrollees are actually in HMOs. The rest are in partially capitated prepaid health plans and fee-for-service primary care case management programs that operate as loose networks of providers.

Third, despite widespread interest in managed care, enrollment varies markedly across States. Eight States have more than 25 percent of their Medicaid population enrolled in managed care, but 17 have no beneficiaries in such a plan.

Fourth, managed care in Medicaid takes place against a backdrop of a Medicaid program that is often inadequate in terms of its payment rates in the fee-for-service sector and already has limitations in access to care for its beneficiary group. We at the Kaiser Commission have just completed an extensive review of over 100 articles on Medicaid and managed care. I will say, as the GAO did, that it is very difficult to generalize from the studies we have reviewed and in fact the conclusions are very inconclusive.

Most of the plans reviewed were not subject at the time they were conducted to rigorous evaluation. The definition of managed care varies widely across the plans, and many of the studies are early demonstrations that differ significantly from today's programs. However, some of the general results from these studies are that Medicaid managed care does change utilization of health care services with some reductions in inpatient use, nonurgent emergency room services, and specialist referrals, some increase in physician care, and mixed results in terms of improvements in use of preventive services.

However, managed care under Medicaid does not necessarily save money in large part because most of the populations enrolled in managed-care programs are the less expensive AFDC population

and not the more expensive disabled populations where the large costs are. Where there have been savings, most have been in the fully capitated models.

There has also not been a measurable effect on quality of care from the Medicaid managed care experience in comparison to fee-for-service. The studies all do, however, point out that any kind of a managed care implementation requires considerable implementation effort and patient and provider education for a successful program. Therefore, when we look from the Medicaid experience to health care reform for its implications, it is important to remember that managed care is not a magic bullet to improve access and save dollars. It requires substantial planning, up-front assistance to plans and beneficiaries, and ongoing monitoring.

Managed-care systems take time to develop, low-income patients need additional counseling and supportive services to make these systems work. An insurance card alone will not bring the resources necessary to develop services in underserved areas. Capacity development must be combined with insurance.

And finally, and most importantly, top quality standards and monitoring are essential to protect against poor quality providers and the underservice that we have too often seen in the Medicaid program in either a fee-for-service or managed-care system. Poorly designed, underfinanced and ineffectively monitored programs can lead to major problems for both patients and health care providers.

It is critical that in enacting health care reform we do not reinvent all the problems that undermined access to care for low-income Medicaid beneficiaries in our current program. Thank you very much.

[The prepared statement and attachments follow:]

Diane Rowland, Sc.D.
 Testimony before the Subcommittee on Health
 Committee on Ways and Means
 U.S. House of Representatives
 February 2, 1994

Good Morning, Mr. Chairman and Members of the Committee. I am Diane Rowland, Senior Vice President of the Henry J. Kaiser Family Foundation and Executive Director of the Kaiser Commission on the Future of Medicaid. The Commission was established by the Henry J. Kaiser Family Foundation in 1991 to serve as a forum for analyzing, debating and proposing Medicaid and other health reforms with the overarching goal of improving access to health care for low-income Americans. The fourteen-member bi-partisan Commission is chaired by James Tallon, Jr., President of the United Hospital Fund and former Majority Leader of the New York State Assembly.

In its work, the Kaiser Commission has endeavored to gain a deeper understanding of the accomplishments as well as problems facing Medicaid today. We have especially been concerned with gaps in coverage of the poor under Medicaid, barriers to access to health care for its beneficiaries, and the unprecedented growth in Medicaid spending. Most recently the Commission has undertaken an extensive review of more than 20 years of research on Medicaid managed care to gain a better understanding of the promise and potential pitfalls that managed care holds for the nation's poor.

I appreciate the opportunity to share with you some of the Commission's findings on Medicaid's role in serving low-income Americans, its experience with managed care, and the lessons from the Medicaid experience that can be applied to national health care reform.

Medicaid and Coverage of the Low-Income Population

Medicaid is the nation's major public financing program for providing health care coverage to low-income families and long-term care to low-income elderly and disabled people. Since its enactment in 1965, this joint federal-state, means-tested entitlement program has been on the frontline in meeting the health care needs of our country's most vulnerable citizens. From its beginnings as a health care financing program primarily for welfare recipients, Medicaid has evolved into a major safety net for the needy -- today serving one in ten Americans and paying 12 cents of every dollar spent on health care.

The Medicaid program serves diverse populations with complex and differing health care needs. It is the key provider of health insurance for four very distinct population groups -- low-income families that lack insurance; low-income elderly people who need help with filling gaps in Medicare benefits; disabled elderly who need long-term care services; and the nonelderly disabled population who need acute and long-term care services. In 1992, Medicaid served nearly 31 million people and was the chief source of health insurance coverage for 21.7 million people in low-income families. Today, one in five children receive health care coverage through Medicaid. In its 30 years of operation, Medicaid has reshaped the availability and provision of medical care to the poor. Medicaid coverage, in the absence of alternative insurance, has a demonstrated positive effect on health status, access to care, and satisfaction with the health care system. Yet, despite its many successes, limitations in basic program design and financing have compromised its ability to function fully as a safety net and evolve to meet the growing needs of the vulnerable populations it serves. Its complex categorical, income and asset requirements preclude it from assisting all poor Americans. As a result, one half of the nation's poor fall through the Medicaid safety net and nearly 11 million have no health insurance coverage at all (Figure 1).

Moreover, Medicaid has become a costly program for its federal and state funders. In 1993, Medicaid spent an estimated \$130 billion in federal and state dollars, accounting for 12 percent of the nation's health care spending. In recent years, annual Medicaid spending growth has exceeded 25 percent a year, straining both federal and state treasuries.

Unable to constrain the rate of medical cost inflation in the overall economy while facing continuing pressure to expand Medicaid coverage to more low-income people, states have looked to alternatives, particularly managed care, in hopes of finding a way to address rising costs and limited access to care. The use of Medicaid managed arrangements has increased considerably in the last decade, reflecting the belief held by many that managed care can be embraced as an overall health care access, cost

containment, quality improvement and budgeting strategy.

Current Status of Medicaid Managed Care

Managed care under Medicaid today is a mixture of different models and approaches to organizing health care delivery. Generally speaking, all managed care plans share certain features, including: formal enrollment by individual patients, formal contractual agreements between providers and payers, and some level of gatekeeping performed either by the primary care physician or a separate administering arm of the payer or both.

Despite these basic features, there is no single definition of managed care and variations on the managed care theme are almost endless. Medicaid managed care models range from tightly constrained group health practices such as staff model health maintenance organizations (HMOs) to fee-for-service arrangements operating as loose networks of physicians, hospitals and other health care providers. Medicaid managed care systems can be divided into three major types of models: full-risk plans in which Medicaid agencies pay plans a capitation fee per person in advance for a comprehensive range of services; fee-for-service primary care case management (PCCM) programs in which a "primary care gatekeeper" is responsible for approving and monitoring the provision of most services; and prepaid health plans in which a plan receives a fixed capitated fee per enrollee for a limited range of services and may also provide or authorize additional services on a fee-for-service basis.

Virtually from Medicaid's inception, state agencies began to contract with HMOs and other types of prepaid health plans. Early HMO contracts were developed in two states already familiar with the HMO concept, Washington and New York. To curb escalating costs, California began promoting prepaid health plans as a cost containment strategy in 1971 with highly publicized and negative results. Marketing abuses combined with underservice to plan beneficiaries characterized the California experience.

As a result of problems occurring in California, limitations were placed on Medicaid's use of prepaid health services in the 1970s. However, in the early 1980s, in response to budget cuts and state calls for more flexibility, new statutory and regulatory changes were enacted. These changes helped foster the growth of Medicaid managed care by authorizing the development of more loosely structured systems. States have actively responded to the greater flexibility given to them by the federal government. Currently, many are experimenting with managed care approaches designed to solve problems such as low provider participation, increasing Medicaid costs, and a rising dependence on emergency rooms as a source of care.

The growth in the number of Medicaid beneficiaries enrolled in managed care has been dramatic. In 1983, 750,000 beneficiaries, one percent of the Medicaid population, were enrolled in managed care. A decade later, 4.8 million persons, approximately 15 percent of the entire Medicaid population, is enrolled in some form of managed care (Figure 2). In recent years, most of the growth in managed care has come from expanded enrollment in PCCMs.

Over half of the 261 Medicaid managed care plans are HMOs which include both state defined and federally qualified plans (Figure 3). Sixty percent of Medicaid HMO plans are state-defined. Of the 4.8 million Medicaid enrollees in managed care, 41 percent are in HMOs, one quarter are in prepaid health plans and about one third are in PCCMs.

The rise in the number of states offering Medicaid managed care programs is also striking. In 1981, 85 percent of the Medicaid managed care enrollment was in four states -- California, New York, Maryland, and Michigan. In 1993, 39 states and the District of Columbia operated 261 Medicaid managed care programs with California, New York, Maryland, and Michigan accounting for 32 percent of the total managed care enrollment. In addition, thirteen states have indicated to the Health Care Financing Administration that they intend to implement new additional managed care programs during 1994. Despite widespread interest in managed care, enrollment varies markedly across states. Eight states had more than 25 percent of their Medicaid beneficiaries enrolled in managed care in 1992, but most states had few beneficiaries enrolled in managed care (Figure 4). Seventeen states had no managed care program.

In the states with managed care programs, the principal managed care enrollees are Aid to Families with Dependent Children (AFDC) households which are overwhelming comprised of women of child-bearing age and their dependent children. Eighteen states also offer managed care plans for disabled or elderly beneficiaries eligible for Supplemental Security Income (SSI), but less than one percent of the disabled Medicaid

population is enrolled in managed care. Thus, Medicaid managed care enrollees are disproportionately young women with relatively limited education and young children who live in poverty.

Review of the Literature

Given the expanded use of managed care in the Medicaid program, the Kaiser Commission has undertaken an extensive review of the published literature on managed care and low-income populations in order to assess the impact of these care arrangements on the low-income population. In reviewing more than 100 studies, the Commission found that it is difficult to draw definitive conclusions or to generalize about the successes or failures of managed care. This is due to the fact that managed care plans vary tremendously in structure and scope and often were not subject to rigorous evaluation. It is also worth noting that many of these plans represent earlier models and not necessarily the kinds of plans operating today. The lack of both a single definition of managed care and a common understanding of which entities fit what definition limits the potential for generalizing managed care's strengths and weaknesses based on Medicaid's experience.

Many of Medicaid managed care programs reviewed in these studies involve evaluations of service delivery demonstrations of limited duration. Many of the programs lacked proper controls to permit valid comparison of managed care versus traditional delivery systems. In a number of cases, evaluations appear to have been conducted at a point too early in the life of the demonstration to permit valid or reliable findings. The impact of these demonstrations on cost, quality, access and health status may be transitory or inaccurately measured over the short term.

Yet, despite these limitations, certain themes and trends do emerge that permit a general assessment of how managed care has worked for low-income and Medicaid populations. Although the results are often mixed, the research indicates that Medicaid managed care appears to change utilization of health care services, is unlikely to necessarily save money, and has not had a measurable effect on quality of care in comparison to fee-for-service Medicaid.

Managed Care's Impact on Access to Care

Health care utilization patterns appear to change when Medicaid enrollees join managed care programs. A recent Hurley, Freund, and Paul analysis of 25 Medicaid managed care programs, for example, found that 44 percent of the programs were associated with an increase in the number of physician visits, 32 percent were associated with a decrease, and the remainder were unchanged. Most studies find reductions in inpatient use, non-urgent use of emergency room care, and rates of specialist referrals for Medicaid enrollees in managed care compared to fee-for-service arrangements. Very few studies that measured reduction in the use of health services among managed care enrollees, however, contain follow-up measures to determine whether utilization reductions involved medically necessary care, or unnecessary or inappropriate care.

Moreover, results with preventive care have been largely mixed. There is little evidence to suggest that managed care boosts utilization of preventive health services for Medicaid beneficiaries. Managed care does not appear to appreciably increase access to immunizations and prenatal care when compared to traditional fee-for-service under Medicaid. What is notable is that immunization rates and the adequacy of prenatal care under Medicaid (regardless of fee-for-service or managed care approach) is far below national averages. The findings with regard to well child care and preventive gynecological care such as breast exams and pap smears are inconsistent. While some studies report improvements under managed care, others find that patients get fewer preventive services.

All major studies have focused on AFDC parents and children; few studies have examined whether managed care can provide effective care to persons with physical disabilities and mental illness. Because of the ongoing and complex clinical and support needs of the patients, and the difficulty in calculating risk-based capitation payment rates, special populations do not easily fit into managed care programs. Most managed care programs are not geared to SSI clients, who have primarily chronic health care needs, and are less likely to have the experience necessary to serve special needs populations. This is clearly an uncharted area.

Managed Care's Impact on Health Care Costs

Although many supporters of managed care believe that managed care will save

money, the evaluations to date are not supportive of this conclusion. While most studies find that Medicaid managed care programs achieve cost savings, others claim that they operate at costs similar to or above those expected of traditional Medicaid. Hurley, Freund and Paul's analysis of 25 Medicaid managed care programs showed that 76 percent of these programs had experienced a decrease in costs when compared to fee-for-service, but savings were typically from 3 to 15 percent. Some studies show that savings achieved from a decline in the use of hospitals and emergency rooms are offset by increased use of primary care services. Others found that savings experienced from lower rates of hospitalization and emergency room use were offset by an increase in ambulatory costs.

It is important to note that when cost savings have occurred it is not for all plans, but usually for fully capitated plans. Several studies found that staff and group practice programs are more likely than loosely configured fee-for-service arrangements to achieve cost savings. These findings bear out the 1992 Congressional Budget Office report on public and private managed care programs.

There is also no consensus in the literature on whether programs must have mandatory enrollment to achieve cost savings. In some studies, mandatory enrollment programs were more likely to experience cost savings than programs in which managed care enrollment is voluntary, yet others show increased savings in voluntary enrollment plans. Apparent savings in voluntary enrollment programs, however, may reflect a healthier population enrolling into managed care arrangements, rather than actual savings.

Very few studies have examined whether savings achieved through managed care can be attributed at least in part to the use of non-network providers by patients experiencing delays in gaining access to in-plan services. If managed care holds down costs to the sponsoring payer, but pushes up health care costs to other payers, it is difficult to classify the results as cost-effective overall. For example, few studies have measured whether Medicaid patients continue to use hospital emergency room services which would show up as uncompensated care.

Managed Care's Impact on the Quality of and Satisfaction with Care

Quality is extremely difficult to measure and can only be measured over a longer period of time than most of these studies. Health care quality can be measured in a number of ways ranging from the clinical appropriateness of care furnished, service delays, and timeliness of care, to health outcomes and perceived health status. The few studies that have been conducted in this area have not detected measurable differences in quality of care provided in managed care compared to fee-for-service among Medicaid beneficiaries. For instance, several studies have found little difference in birth outcomes among pregnant women enrolled in managed care compared to those enrolled in traditional fee-for-service programs.

It must be noted that study results concerning changes in health status must be viewed with particular caution. Many of the studies report no worsening of health status following enrollment in managed care arrangements. It is doubtful that over the short time span covered by most of the managed care demonstrations, health status either would (or could) change appreciably. Indeed, long term health status improvements or declines might well be missed in short term studies. Given the relatively poor health status of Medicaid beneficiaries (as measured by factors such as a heightened incidence of low birthweight and infant mortality, low immunization rates, and limited use of preventive health measures), it is questionable whether the mere absence of worse outcomes should be viewed as an achievement.

Studies indicate that many Medicaid managed care contracts are ambiguous with respect to the scope of service coverage, the credentials of participating providers, and the range of care that must be offered. This is clearly an area where developing standards for quality assurance and monitoring is extremely important. An initiative is underway at HCFA that aims to subject Medicaid managed care plans to quality assurance standards. The initiative creates a framework as well as specific guidelines for the state Medicaid agency, the participating plans, and an independent review entity in monitoring quality.

Most studies on the impact of Medicaid and managed care on patient satisfaction conclude that satisfaction with managed care is highly influenced by whether enrollees can remain with their usual provider of care. Disruption or preservation of existing patient-physician relationships are a major determinant of patient satisfaction. When Medicaid patients are allowed to remain with their prior usual source of care, satisfaction

increases. Preserving pre-enrollment physician relationships was the largest and most consistent reason for disenrolling from an HMO in a 1986 HCFA survey.

The entire literature on Medicaid and managed care and history on implementation show that it takes considerable effort to educate and orient beneficiaries in the use of managed care systems. Time spent in these areas are critical components of improving beneficiary satisfaction with plans and reducing voluntary disenrollment. Research has shown that the longer the time spent on managed care implementation, including beneficiary education in selecting managed care providers and using services via face-to-face counseling, the less likely enrollees are to voluntarily disenroll.

Lessons from Medicaid Managed Care

An assessment of Medicaid and managed care must be based on an understanding of some of the unique characteristics of the Medicaid program and the population it serves. When one looks at the population served by Medicaid managed care, we are predominantly reviewing the experiences of welfare recipients and their families in gaining access to care. We are also comparing these beneficiaries' experience in managed care to their experiences in an often fragmented and ineffective fee-for-service delivery system characterized by low payment to providers and an inadequate supply of primary care practitioners.

While managed care holds the promise of providing an established network of providers and coordinated care for this population, it has also been undertaken within the context of many of Medicaid's structural flaws in eligibility and provider payment policy. Whether managed care will work for the low-income population requires examining the structure of plans and providing an improved financing base.

Some of the lessons raised by our review are:

- ***Unstable eligibility for Medicaid, causing enrollees to lose their plan membership and disrupting care:*** Medicaid's eligibility policies can make enrollment in a managed care program problematic. Guaranteed enrollment regardless of fluctuations in income and employment status are essential to both assure access to timely and cost effective care. One of the benefits of universal coverage will be continuous enrollment in managed care plans.
- ***A patient population that is disproportionately young, poorly educated, and inexperienced in navigating a complex health care system:*** Medicaid patients and the poor uninsured population may experience difficulties in accessing health care services under the best of circumstances. Managed care, although it may be designed to promote more efficient and effective delivery of care, may prove to be difficult for those with little experience in dealing with complex networks with new rules and limitations. Unfortunately, for many, barriers to health care services result in the postponement of care until relatively minor conditions have evolved to acute and life-threatening conditions. Patient counseling and education are important components to any managed care plan.
- ***Plans' inexperience in marketing to and caring for low-income patients:*** Many health plans are only recently beginning to consider Medicaid beneficiaries as a potential market. These managed care plans have little experience in dealing with the special and complex health care needs and practices of low-income people. It will be critical to assure that plans that are enrolling low-income people assure that their health care providers are convenient and accessible to their enrollees as well as sensitive to their health care and cultural needs.
- ***Low provider payment rates that deter greater participation by established plans:*** It is crucial to assure that there is equity in the rates paid for care delivered to private patients and those enrolled in Medicaid or any other plan serving low-income people. While payment inequities persist, obtaining sufficient numbers of practitioners, particularly physicians, to care for the poor remains an unachievable goal.
- ***Exclusion of minority physicians and community based health clinics that historically have served patients in poor communities from managed care***

plans: The studies reviewed indicate that managed care plans need to include the traditional providers to the low-income population. Managed care can adversely affect office-based and clinical health care providers who provide good care in community settings, but who are not equipped for change. Many of these providers lack the knowledge or resources to modify and adapt their practices to satisfy the requirements of managed care plans and will need special assistance to make the conversion to managed care.

- **A shortage of primary care provider capacity on which to build a managed care system:** There continues to be a shortage of providers to serve those live in medically underserved poor communities. Low-income residents of inner cities and remote rural areas are particularly vulnerable to provider shortages. In order to effectively serve the low-income population, it is critical to assure that these areas have sufficient numbers of providers and practitioners to provide timely health care services.
- **The potential of prepaid managed care systems to foster inappropriately low use and create adverse provider profit incentives:** Special protections must be put in place to assure quality and access to health care for low-income enrollees. Underservice can take many forms. Care must be accessible to patients; they must have all of the options provided to private sector patients, and quality assurance mechanisms must be implemented. Without these safeguards, the poor will continue to be vulnerable to providers with purely financial interests at stake. Monitoring quality of care is extremely important in any health plan.

The findings of the Kaiser Commission analysis indicate that these problems can be identified and at least partially remedied through specific policy and structural reforms, up-front financial investments, innovative fee structures, and technical know-how and skill in adapting managed care to the needs of particular individuals, families and communities. These studies also show that with either fee-for-service and managed care, poorly designed, under-financed, and ineffectively monitored programs can lead to major problems for both patients and health care providers.

As the health care system moves to managed care, these issues must be tackled. Much is known from studies of both managed care and fee-for-service systems about how to make health care arrangements compatible with the needs of poor patients. Despite their limitations, these studies suggest further direction for reform and begin to identify important policy issues to consider in health care reform.

Implications of Health Reform for the Poor

Managed care is now a prominent feature of many health reform proposals, including the plan proposed by President Clinton. By encouraging enrollment in managed care, these proposals seek to improve coordination of care and contain costs. By including Medicaid patients in these managed care plans, these proposals seek to provide access to mainstream health plans and mainstream medical care for the low-income population.

The health reform goal of providing universal coverage for all Americans and integrating care of the poor into the health care delivery system for all Americans will address the most notable deficiencies under Medicaid today. Universal coverage is critical to end the gaps in insurance today that leave 11 million people with incomes below poverty uninsured. Moreover, universal coverage will remove the current variations in coverage of the poor across states that result from differing policy choices in program coverage made by the states. Integration of the poor into the delivery for all Americans also offers the promise of a single standard of care for all Americans.

However, the Medicaid experience with managed care and fee-for-service medical care offers some cautionary lessons. If the poor are to have access to care that is comparable to higher income individuals, they may require more than a health insurance card that entitles them to care under the health system. Lower income individuals often have more complex health needs and less experience navigating the health system and may require more services, as well as counseling in how to use the system. Plans that serve the low-income population should be carefully monitored to assure high standards

of care and protect against underservice in capitated models. Maintaining a broad mix of patients of all incomes in each plan can assist in ensuring quality.

Moreover, the Medicaid experience with managed care also points to the importance of providing supportive services to the low-income population to improve access to care. Cost-sharing requirements and payments for uncovered services, such as vision or dental care, are often a severe financial burden for low-income families. Assistance with these expenses and the provision of supplemental benefits for low-income populations will facilitate their access to mainstream medical care in either a fee-for-service or managed care setting.

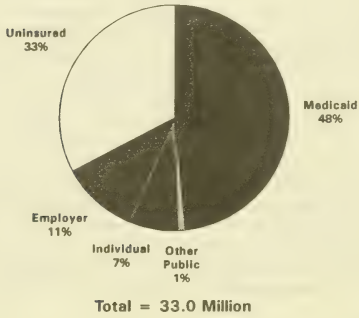
It should also be recognized that financing alone is often insufficient to attract an adequate supply of providers to low-income and underserved areas. Additional incentives to providers to locate in underserved areas combined with assistance in infrastructure development may be necessary to provide adequate resources in low-income communities. Incorporating traditional care providers into new managed care plans may also be necessary to avoid disruption of community care relationships.

Health care reform offers great promise to overcome many problems that have limited Medicaid's effectiveness as a health financing program for the poor. Universal coverage will help to provide improved access and more financial security for the low-income population, but expanded insurance must be coupled with financial safeguards for poor and near-poor Americans, adequate provider rates, and an improved health care delivery system to assure that all Americans can benefit from our health care system.

We look forward to working with you in the Congress to bring fundamental reform to our health care system and to improve coverage and access to care.

Thank you for this opportunity to appear before the Committee today.

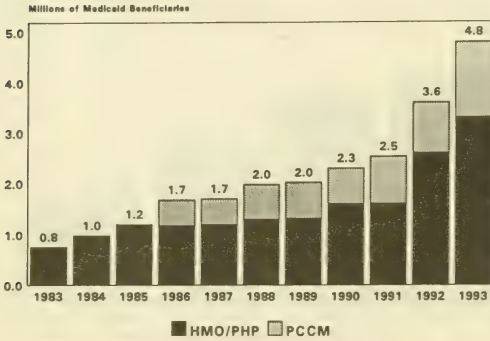
Figure 1: Distribution of the Poor Population under Age 65, by Insurance Coverage, 1992



Source: EBRI, 1994.

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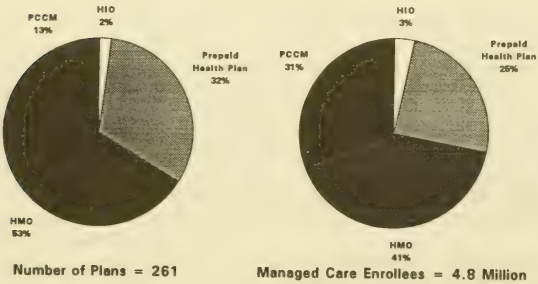
Figure 2: Growth in Medicaid Managed Care Enrollment, 1983-1993



Source: HCFA, Health Care Financing Review, 1992 Supplement.
HCFA Medicaid Managed Care Enrollment Report, June, 1993.

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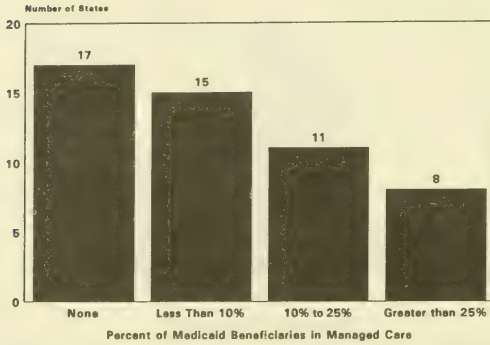
Figure 3: Medicaid Managed Care Enrollment, by Type of Plan, 1993



Source: HCFA Medicaid Managed Care Enrollment Report, June, 1993.

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Figure 4: Percent of Medicaid Beneficiaries Enrolled in Managed Care Programs, by State, 1992



Source: HCFA, Health Care Financing Review, 1992 Supplement.

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Chairman STARK. Thank you.
Ms. Dooha.

STATEMENT OF SUSAN M. DOOHA, MEMBER, STEERING COMMITTEE, NEW YORKERS FOR ACCESSIBLE HEALTH COVERAGE, AND CO-FOUNDER, NATIONAL TRANSPLANT SUPPORT NETWORK

Ms. DOOHA. Good morning, Mr. Chairman, members of the subcommittee. I am accompanied today by Kim Calder of Cancer Care and Bob Griss of the Center on Health and Disability. My name is Susan Dooha, and I speak on behalf of New Yorkers for Accessible Health Coverage, a coalition of organizations representing a diverse community of people with chronic conditions and disabilities.

Most of us will experience some health care need during our lives, so we believe that the experience of people with disabilities and chronic conditions offers an important litmus test for health care reform. We thank you for the opportunity to describe the impact of managed-care plans on access and quality of services for people with disabilities and chronic conditions.

Although managed-care plans have had limited experience with people with disabilities, we have consistently observed that managed-care practices have a discriminatory impact on our communities. Managed-care gatekeepers are defined as general practitioners. The gatekeeper may have little awareness of the comprehensive services needed by people with specific chronic conditions and disabilities. The consequences can be tragic.

I ask you to hear Sandy's story. Sandy, a hemophilic child, was treated at a managed-care facility, misdiagnosed by a primary care gatekeeper as having the flu. The child was not referred out to a hematologist specializing in hemophilia. Three days later, Sandy was admitted to a hospital with an intracranial hemorrhage.

Lack of immediate and appropriate care resulted in Sandy's death. As an alternative, care coordination centers have developed, often with the support of the chronic condition and disability community. These centers enable access to providers with the necessary expertise and the appropriate range of services needed for comprehensive treatment.

As a result, individuals with chronic conditions or disabilities are able to avoid secondary conditions, retain functioning, and avoid more intensive, institution-based care. This is what prevention means for people with disabilities.

Jean's story illustrates. Jean's pre and post kidney transplant care was provided by a transplant center. Her employer switched to a managed-care plan that would not pay for continued care at the transplant center. Her managed care gatekeeper was unfamiliar with the aggressive attention needed to manage post-transplant immunosuppression. He failed to identify early signs of organ rejection through complex laboratory screens and monitoring of symptoms. Jean lost her transplanted kidney and requires dialysis.

Problems with gatekeepers are made worse where managed-care plans rely on provider reimbursement strategies that do not sufficiently insulate providers from financial risk. The gatekeeper has

a financial incentive to underserve when the cost of care exceeds the average cost calculated.

Ellen's story shows what happens. Ellen's gatekeeper diagnosed her severe headaches, numbness and loss of control of her left arm as arthritis. When symptoms worsened, he told her to stop carrying her briefcase. Two months later she sought admission to an out-of-network hospital where tests, including an MRI, showed a brain tumor. She was told that the failure to order appropriate tests and to refer her to a neurologist resulted in her deterioration.

Again, we thank you for requesting our statement. A brief summary of our recommendations follows.

Managed-care plans must be prohibited from discriminating based on disability, health status, or anticipated need for service. Individuals whose care necessitates coordination by a specialist must have the option of designating a specialist as their gatekeeper.

Individuals with chronic conditions or disabilities must have the option to seek care from care coordination centers specific to their disability as essential community providers.

Plans must not subject providers to inordinate financial risk for prescribing appropriate services. No payment should be made which is directly or indirectly a reward for limiting medically necessary services to individuals.

Plans must insure timely access to necessary care. Regulations must be established that govern access which recognize medically fragile conditions.

The federally guaranteed benefit package must be comprehensive, not subject to the arbitrary limits at the discretion of the health plan.

It must include treatment recommended for the person's condition in authoritative medical and scientific literature, including off-label usage of pharmaceuticals and coverage for all patient care costs incurred in clinical trials.

Consumers should participate in governing boards responsible for the development of guidelines and the regulation of health care delivery.

Again, I thank you.

[The prepared statement follows:]

**TESTIMONY OF SUSAN M. DOOLA
NEW YORKERS FOR ACCESSIBLE HEALTH COVERAGE**

Good morning, Mr. Chairman, members of the Subcommittee. My name is Susan M. Dooha. I am a co-founder of the National Transplant Support Network, a grassroots network of organ transplant recipient support groups. NTSN is one of the more than 40 organizations participating in New Yorkers for Accessible Health Coverage (NYFAHC). NYFAHC represents a diverse community of people for whom health care access is a priority, including many with chronic conditions, serious illnesses or disabilities.

NYFAHC was created in 1991 in response to proposed changes in the premium rating structure of Empire Blue Cross Blue Shield that would have left countless medically fragile New Yorkers priced out of health insurance. Groups representing the medically fragile - people with life-threatening or chronic conditions and disabilities, the elderly and others deemed "high risks" - banded together to address the crisis responsibly.

Our founding principles, directed toward statewide insurance reforms, were to advance the accessibility, affordability, continuity and comprehensiveness of insurance coverage, as well as to broaden participation in the market so as to spread the risks across the marketplace as much as possible. We acted on these principles by leading the grassroots support for community rating and open enrollment legislation and, in 1992, overcame strenuous and well-financed opposition by the commercial insurance industry to secure a historic victory for millions of New Yorkers.

Today, we offer our experience, analysis and recommendations on the topic of managed care, speaking from the perspective of people with chronic conditions and disabilities, particularly those who are medically fragile. We realize that managed care is often cited as an effective cost-containment tool and that some proposals for health care reform rely heavily on managed care. We are pleased to be here at a time when the cost-containment claims of managed care are under scrutiny. We thank you for the opportunity to describe the impact of managed care plans on access, quality of services and consumer satisfaction for people with chronic conditions and disabilities.

A Disability Perspective

Managed care appears to address concerns shared by people with disabilities. As we try to reform the system to make it work for the country as a whole, however, we must work to prevent managed care from impairing access to quality care for people with disabilities and chronic illness. Some aspects of managed care appear neutral but have a discriminatory impact on people with disabilities. Therefore, it is essential that our reforms account for the experience of the disability community. Otherwise, a reformed health care system may face ethical and legal challenges. Also, a reform proposal that fails to address the health care needs of such a large portion of the population, 43 million with disabilities and millions more with chronic health conditions, may not be appealing to the American people.

In addition, the disability perspective offers an important litmus test for health care reform. Most persons, due to congenital birth condition, injury, disease or simply due to the process of aging, will experience some health care need during a lifetime. Therefore, the experience of people with disabilities will help to identify issues that will affect most Americans as well as help fulfill the promise of the Americans with Disabilities Act.

Managed Care's Limited Experience With Disabilities

People with disabilities encounter an anti-disability bias in accessing the managed care system. They face barriers to enrollment in private and public managed care programs.

Managed care plans engage in biased selection in order to enroll healthier people. A study, by the U.S. Congress's Office of Technology Assessment, of private health maintenance organizations showed that they reject 24% of individual applicants. This is significant because the individual subscriber pool is widely understood to contain a high proportion of people with disabilities and chronic conditions. Managed care plans also discourage people with disabilities from joining by excluding coverage of necessary treatments.

Studies of State Medicaid managed care programs show that most programs enroll AFDC or AFDC-related populations who have significant access problems and do not enroll SSI and SSI-related individuals. A recent GAO report has described AFDC recipients as "generally requiring fewer and less expensive services than the SSI population." Some Medicaid programs have exempted people with disabilities from participation in Medicaid managed care demonstration projects. In addition, although government studies of Medicaid managed care frequently refer to problems for people with chronic health conditions or disabilities, these problems have not been the subject of government study in and of themselves.

One may say that persons with disabilities have been systematically excluded from these programs because managed care programs have not yet determined how to provide them with adequate care, or one may say that managed care providers engage in biased selection, enrolling healthier clients, avoiding sicker ones, in order to minimize losses and maximize profits. In either event, insufficient attention has been given by managed care plans to the care coordination needs of persons with disabilities.

Gatekeepers for People with Chronic Conditions or Disabilities

Organizations that principally serve or represent persons with disabilities have consistently observed that managed care practices that appear to be neutral to the temporarily able-bodied consumer may in fact have a discriminatory impact on persons with disabilities or chronic conditions. For example, problems with gatekeepers have received considerable attention in articles and position papers published by organizations that principally serve or represent people with disabilities, based on the experiences and observations of people with disabilities.

Managed care's proponents say that a gatekeeper, defined as a "primary care" practitioner, enhances the quality of care by stressing prevention and primary care, preventing the need for acute care. The gatekeeper monitors care and facilitates access, making referrals for needed services and preventing overutilization. These assertions are based on the managed care experience of those who are temporarily able-bodied not those with disabilities for whom gatekeepers can cause problems.

The first problem arises because gatekeepers in managed care programs are defined as "general practitioners." This is intended to deter inappropriate reliance by average consumers on specialty care. However, general practitioners may have little awareness of or experience with the comprehensive services needed by people with specific chronic conditions and disabilities, and the consequences can be harmful, even tragic.

Saridy, a hemophilic child with an intracranial hemorrhage, was treated at a managed care facility. He was misdiagnosed by a primary care physician as

having the flu. As a result, he was not referred out to a hematologist specializing in the treatment of hemophilia. After three days, Sandy was finally referred and admitted to a local hospital. The lack of immediate and appropriate health care resulted in Sandy's death.

In addition, disability analysts have indicated that the use of a single gatekeeper may be inappropriate for some persons with disabilities. An interdisciplinary team with a care coordinator assigned to the individual may be needed to identify and relate complex issues and decide upon referrals. However, managed care programs do not necessarily have a full range of specialists available to participate as team members. This can result in limited access to essential services, and long waiting times for appointments and referrals, which interrupts the continuity of care needed by persons with chronic conditions or disabilities.

Managed care gatekeepers are neither trained in, nor paid to ensure, the provision of care coordination. They are employed to identify strategies for containing the costs associated with high cost cases. Even in those instances where the gatekeeper is expected to coordinate care, there are few incentives to spend time on care coordination.

Karen had a stroke brought on by cerebral hemorrhage. To avoid additional strokes, delicate surgery removed abnormal blood vessels. The surgery was successful, but testing and therapy are required to complete treatment. Her managed care gatekeeper told her he doesn't understand the tests essential to monitoring her progress. He said he has "given up" on the complex and time-consuming process of making referrals and told her to get some other doctor to make them for her. Delays in referral for treatment may eliminate her chances of regaining her pre-stroke level of functioning.

During recent years, care coordination centers have developed, often with the support and involvement of the chronic illness and disability community. These centers provide persons with access to a center that specializes in treating their particular conditions. This means that these centers have assembled providers with the necessary expertise to provide the appropriate range of services needed for comprehensive treatment. It means that the centers are up to date on developments in the particular condition or disability field. It means that providers see enough people with a particular condition to be able to recognize and respond to subtle changes in health status, so that the person with the disability can maintain quality of life. As a result, individuals with chronic conditions or disabilities are able to avoid the development of secondary conditions, retain functioning, and avoid more intensive institution-based care. Many current managed care programs deny, delay or disrupt access to these coordinated care centers that arguably provide a higher quality service than is available elsewhere.

Jean's pre- and post-kidney transplant care was provided by a transplant center. Her employer switched to a managed care plan that would not pay for continued care at the transplant center. Her managed care gatekeeper was unfamiliar with the aggressive attention needed to manage post-transplant immunosuppression. He failed to identify early signs of organ rejection through monitoring complex laboratory screens and symptoms. He failed to manage early signs of rejection. Jean lost her transplanted kidney and requires dialysis, a significantly more expensive treatment.

People with disabilities and chronic conditions believe that choice of provider is an essential quality assurance mechanism. People with disabilities have fought for and won victories acknowledging them as adults capable of living independently in the community. A part of this self-empowerment struggle has

been to establish a relationship with their health care providers that might be characterized as a partnership. This partnership then works together to establish a high quality treatment and management plan. This way of working together, which emphasizes the capacity to exercise choice, is important to the continuing independence of persons with disabilities. However, managed care systems remove decision-making from the doctor/patient relationship and place it in the hands of case managers. This could be viewed as a discriminatory denial of the autonomy of a person with chronic illness or disability.

Amy has multiple sclerosis and participates in an MS care coordination center. She takes a complex regimen of medications to manage MS symptoms, including a seizure disorder and chronic eye inflammation that may lead to blindness if not properly treated. Her primary care doctor, a neurologist, refers her to specialists at the center who are familiar with MS. She is sure that her continuing vision is due to the center's ability to work in partnership with her to maintain her condition. She will not have access to the center when her care is turned over to a managed care provider by her employer. She reports feeling "disempowered."

People with disabilities and chronic conditions are forced to disrupt longstanding relationships with their providers when forced into managed care plans. The problem is exacerbated by the high turnover rate of providers characteristic of some managed care plans. Disruption of provider relationships reduces quality by destroying the continuity of care that is critical to the mental and physical well-being of the individual. Chronic conditions or disabilities may last a lifetime. Long-term management is necessary to provide effective care and to prevent redundant retesting and the provision of unnecessary and more intensive services. A new provider is less likely to notice subtle changes in a person's condition - changes that may require a change in treatment. Also, new providers may not rapidly establish communication with persons with disabilities and poor communication may result in what is called "patient non-compliance," often endangering the stability of the person's condition.

Rita, a very brittle diabetic, was told by her managed care gatekeeper that she should not eat for a day and a half at home before admission for surgery. She expressed concern that she needed her blood sugar to be monitored in hospital during that time. The gatekeeper physician did not respond to her concerns. She didn't comply. When she was admitted for surgery, the anesthesiologist said that he could not proceed, and she was sent home.

While managed care plans often assert that they provide enrollees with a sufficient selection of primary and specialty providers, consumers with chronic conditions or disabilities have found this to be illusory. Managed care networks generally fail to offer the full range of services necessary to meet the real needs of the chronically ill or disabled. Patients may be provided access to a physician with an appropriate specialty, but without knowledge of their condition or care needs. Specialists may be pressed to see more clients than is appropriate, so that waiting times are long, diagnoses are delayed, appointments are short. Even when the provider network is obviously insufficient to meet the needs of a person with a specific health condition or disability, some managed care plans refuse to provide reimbursement for services outside the network attempting to maximize their short-term gain.

Helen participates in a managed care program. She reported a persistent cough to her physician. Her primary care gatekeeper was unable to order tests promptly. Finally, tests done, she waited to see a part-time plan oncologist. When she saw him, he said her records were inadequate. Even without full information, he was ready to begin cancer treatment. Alarmed, she sought an outside provider who told her that due to delays in diagnosis and treatment, she had advanced terminal lung cancer. He recommended a clinical trial. The managed care plan refused to

pay for treatment until they feared losing a lawsuit. Helen hopes to live to see her daughter's upcoming wedding.

Gatekeeper Problems Exacerbated by Financing Schemes

Problems with gatekeepers are exacerbated where managed care programs rely on provider reimbursement strategies that do not sufficiently insulate providers from financial risk for services. A GAO report on Chicago-area HMOs found that when more financial risk was shifted to physicians there was a greater risk of inappropriate reductions in care. Similarly, the New York Business Group on Health reported that physicians affected by incentive plans ordered fewer diagnostic tests and sent fewer patients to specialists.

Ellen's managed care plan's gatekeeper diagnosed her severe headaches, nausea and vomiting, loss of control of her left arm, increasing weakness and numbness as arthritis. He x-rayed her left arm and prescribed anti-inflammatory medication. When her symptoms worsened he told her she should stop carrying her briefcase and did not need to see him anymore. Two months later, she was admitted to a hospital out of network, where an MRI showed evidence of a large brain tumor. She was slipping into coma. Emergency neurosurgery was scheduled. She remained hospitalized for radiation and physical therapy to restore functioning to her left side. She was told that failure to make a referral to a neurologist or order an MRI or Cat Scan had unnecessarily resulted in the deterioration of her condition.

Incentives to reduce services create barriers to access for people with chronic conditions or disabilities. This is because some people with disabilities require specialized services and must be actively monitored, returning at regular intervals for supervision and intervention. In the case of life-threatening conditions, costs of actively appropriate providing chronic care can be high. In such situations, a provider who is not sufficiently insulated from risk could perceive that the most cost-effective treatment is no treatment at all.

Abel has severe chronic kidney disease. When he began to have severe pain and difficulty urinating, he went to his managed care program. Although Abel told the doctor about his chronic condition, the doctor who saw him made no attempt to retrieve his records. He sent him home, prescribing aspirin. Abel knew that his symptoms were so severe that he was in danger. He went to a kidney center that had provided his care before he had been forced into the managed care program. They immediately admitted him to a hospital. He required intensive treatment for a week and follow-up care.

Capitation has been described as the most common payment methodology among trend-setting managed care programs. "Average" rates are meant to give providers an incentive to provide primary care and prevent conditions from becoming acute. Wherever the actual cost of medically necessary care for an individual would exceed the "average" cost calculated, however, the primary care physician or the managed care plan has an incentive to underserve the individual.

In some managed care programs, financial incentives to undertreat are heightened. For example, where a managed care plan contracts on either a fee-for-service basis or a capitation basis with a provider, a percentage of the provider's income (typically 15-20%, but sometimes more) is withheld. At the end of the year, the provider's practice is profiled to determine whether they exceeded a targeted number of referrals, tests and hospitalizations, or an average cost estimate. The doctors receive their full compensation only if they have come in below targeted utilization rates or cost estimates.

Some managed care programs use funds withheld from primary care

doctors to create "risk pools." These funds are used to pay for specialty services or hospitalizations. If a surplus in the risk pool exists at the end of the year, the surplus is paid to the physician. If there is a deficit, the provider forfeits the withheld funds. In some schemes, if the portion withheld is not enough, payments to the provider may be decreased or the provider may be obliged to repay the managed care program.

Under these schemes, services provided to particular enrollees may be subject to an arbitrary limit. Obviously, this could cause delays and denials of services that would result in decreased quality of care. They could also cause providers to refuse to treat people with complex health conditions who may need greater levels of service. Such incentives could result in cutting access to health care for high risk patients.

The danger that care would be delayed or denied because of financial disincentives increases where turnover in enrollment is high. Turnover may be high where Medicaid recipients lose their eligibility or in industries where people change jobs with some frequency. In such cases, the managed care program has an incentive to gamble that the adverse impact of a delay or denial of care will not occur until after the person with a disability or chronic health condition leaves the program.

Limitation of Benefits in Managed Care

Managed care programs limit the amount, duration and scope of benefits available. They limit the number of home care visits, respite care, rehabilitation services, and the number of durable medical equipment items even when they are medically necessary and appropriate. Some benefits, such as durable medical equipment, may be excluded altogether. Other benefits may be subject to yearly or lifetime caps.

Managed care programs also limit benefits by imposing separate co-insurance obligations. This means that the client pays a portion of the total bill for durable medical equipment, prescriptions, out-patient mental health services. For people who have chronic conditions or disabilities and as a result need ongoing services, the costs can be prohibitive.

Many people living with chronic illnesses or disabilities, particularly life-threatening conditions for which there are no effective conventional therapies available, rely on innovative uses of existing technologies, and a variety of experimental, investigational and alternative treatments to maintain health and well-being. Many people living with chronic illnesses participate in clinical trials of experimental treatments as perhaps their only hope of effective treatment. Although on most occasions the treatments themselves are provided at no cost by the investigator, there are often associated costs to the consumer which can be quite substantial.

Measuring Managed Care's Quality of Care

In managed care, methods used to measure quality and consumer satisfaction often fail to adequately address the needs of people with disabilities. Consumer report cards and other quality measures which are geared to the needs of a "general" population may be of limited usefulness for people with specific disabilities interested in measuring the managed care program's performance in relationship to their health needs. In a capitated system the managed care plan may actually prefer to receive a poor rating for serving so-called high risk people as a way to discouraging their enrollment, which might otherwise be protected.

Conclusion and Recommendations

NYFAHC understands that the overall shape of health care reform will have an impact on managed care as a delivery system. Consumer representation in governance structures, consumer rights protection and fair financing will determine the imperatives that drive the health care delivery system, including managed care. NYFAHC believes that quality health care becomes affordable when all consumers participate in the same health care system and the costs and risks are distributed equitably throughout the system.

It is necessary to eliminate financial incentives to deny appropriate care. When cost containment motives override concern for appropriate care, people with chronic health conditions and disabilities cannot be assured the accessibility, affordability, comprehensiveness and continuity of coverage necessary to provide quality services. No consumer with a disability or chronic health condition could be satisfied with a system that produces such a result.

Guaranteed choice of provider, without systemic obstacles to appropriate specialists, is the most significant way to protect the quality of care for persons with disabilities or chronic health conditions. Without choice of provider it is difficult to obtain appropriate health related services.

Again, we thank you for requesting our statement concerning the impact of managed care plans on access, quality of services, and consumer satisfaction for people with chronic conditions and disabilities.

Some specific recommendations include:

Gatekeepers - Access to Appropriate Providers

- ◆ Individuals whose care necessitates coordination by a specialist must have the option of designating as their gatekeeper a provider of that specialty who has knowledge of the individual's specific condition.
- ◆ Individuals currently being served by specialists who act as care coordinators, or by care coordination programs designed to meet their unique needs, must not be forced out of such relationships or programs. Individuals with chronic health conditions or disabilities must have the option to seek care from care coordination centers specific to their disability as essential community providers.
- ◆ Plans must ensure timely access to necessary care. Regulations must be established to govern waiting times for tests, appointments and referrals to specialists, pre-authorizations, grievance proceedings and appeals procedures that recognize the medically fragile conditions of certain people with special health care needs.
- ◆ Quality assurance standards must be established by the federal government and enforced by the states regarding the adequacy of the plan's provider network: access to appropriate physicians; ratios of patients to physicians; adequacy of specialty provider networks.
- ◆ Physician incentive plans must not subject providers to inordinate financial risk for prescribing appropriate services to patients. No payment should be made which is directly or indirectly a reward for limiting medically necessary services to individuals.

Comprehensiveness of Benefits

- ◆ A federal regulatory body should determine the guaranteed package of benefits for all persons and develop and implement criteria to use when

deciding to add or eliminate a medically necessary service from the federally guaranteed benefits package.

- ◆ The guaranteed benefits package must be comprehensive, not subject to arbitrary limits on amount, duration and scope at the discretion of the health plan. A full continuum of services must be available including services which prevent secondary disabilities and maintain health or increase functioning. This is what prevention means for people with disabilities.
- ◆ The guaranteed benefits package must include treatment recommended for the person's condition in authoritative medical or scientific literature, including off-label usage of pharmaceuticals. The guaranteed benefits package should include coverage for all patient care costs incurred in clinical trials.

Oversight - Data Collection; Regulation

- ◆ Managed care plans should be subject to regular external audits conducted by an independent regulatory agency. To allow effective civil rights enforcement, audit results should include findings regarding the provision of services to people with health conditions or disabilities
- ◆ Managed care plans should be required to survey plan participants who disenroll and departing providers to ensure that departure is not related to plan practices that interfered with the provision of necessary care.
- ◆ Plans should be subject to process standards that examine credentialing, collection of individual patient care data, utilization and medical record review, reporting of physician terminations and clinical practice guidelines.
- ◆ Plans should be subject to outcome standards that examine health status and satisfaction, timing of encounters, and treatment outcomes.
- ◆ A plan report about the services it has provided should give details on a range of chronic conditions and disabilities. Indicators of disincentives to provide care - including waiting times for appointments or tests - should be monitored and reported to plan enrollees. Grievance process timing and issues should be reported, as should reasons for disenrollment.
- ◆ Where patterns of underservice are discovered, managed care plans should be subject to stringent financial penalties and obliged to comply with a plan for corrective action, enforced by a government regulatory agency.

Consumer Education, Participation in Governance, and Dispute Resolution

- ◆ Consumers with disabilities and chronic conditions should have access to health education and information related to their conditions or disabilities, including information related to new drugs, therapies, or treatment protocols or clinical trials.
- ◆ Consumers with disabilities and chronic conditions, and their representatives, should participate in governing boards responsible for the development of guidelines for the care of conditions or disabilities, and responsible for the regulation of health care delivery.
- ◆ When a plan denies, reduces, or stops providing a health service to an individual, that individual must have access to a grievance procedure and assistance from a consumer advocate. The grievance procedure must be

subject to time limits and there must be an expedited hearing process available. A participant must have access to all necessary information and available support to complete the appeal. Consumer representatives should participate in the design of grievance procedures.

- ◆ Where disputes arise regarding the appropriateness of treatment of a chronic condition or disability, the managed care plan must authorize, in a timely way, coverage for a second opinion. Information regarding the second opinion should be included in any grievance proceeding.
- ◆ If pre-authorization is required for treatment, the decisionmaker should have qualifications in the field or specialty implicated in treatment, and the decision should be based on guidelines for care and on the individual's needs. Authorization of treatment should not be subject to arbitrary limits but should extend for the duration of the condition. Authorization decisions should be made within a specific time limit and should be expedited where necessary to prevent the exacerbation of the condition.

Consumer Rights

- ◆ Managed care plans must be prohibited from discriminating, or engaging in any activity that has the effect of discriminating, against any individual based on disability, health status, or anticipated need for service. The structure, administration, and data collection aspects of managed care plans should be subject to anti-discrimination provisions that broadly prohibit activities that have a discriminatory impact.
- ◆ Any consumer discriminated against based on disability, health status, or need for service should have a private right of action to enforce anti-discrimination protections and to obtain damages and other remedies.

Chairman STARK. Thank you very much.
Mr. Campbell.

**STATEMENT OF MICHAEL J. CAMPBELL, STAFF ATTORNEY,
PENNSYLVANIA HEALTH LAW PROJECT, ACCOMPANIED BY
ANN TORREGROSSA, DIRECTOR**

Mr. CAMPBELL. Good afternoon, Chairman Stark, and Representative Johnson. My name is Michael Campbell, with me is Ann Torregrossa. We are attorneys with the Pennsylvania Health Law Project in Philadelphia. The Health Law Project is a nonprofit legal services program that specializes in health law impacting on low-income Pennsylvanians.

In this capacity, we have been very involved in the issues surrounding Philadelphia's HealthPass program, the State's Health Insuring Organization or HIO.

HealthPass was created in 1986 pursuant to a Federal waiver that permits the State of Pennsylvania to require 100,000 Medicaid recipients in Philadelphia to receive their health care from a managed-care network. The program is soon to be rebid, and will double in size and reach into suburban Philadelphia.

Low-income people in 1986 were very quickly herded into a managed-care system with a promise that they would receive better care. The primary motivation at that time was the need to achieve savings immediately to balance the State budget. We think that many of the same forces at work in the development of the HealthPass program are also at work in the development of the national health reform debate, and our Philadelphia experiences provided us with some hard lessons that we would like to share with the subcommittee.

It would be a shame to repeat the same mistakes twice. I would like to list the lessons that we learned and go back and, hopefully, get through some of the specifics.

First, it is very dangerous to put all of your eggs into one basket. Second, strict oversight of managed-care networks is critical. Third, there must be independent public accountability for managed health care; fourth, health plans need a great deal of time to set up systems if consumer interests are to be protected; fifth, awarding managed-care contracts with guaranteed numbers of locked in members allows the Government to give a for-profit corporation a monopoly subject to abuse.

Next, managed care has not resulted necessarily in high quality care, which was promised for low-income people.

Next, while managed care may not have improved care for low-income people, it certainly has improved profits for some well-connected corporations. Finally, solely switching to managed care is not the real reform that we need in America.

Under the plans before Congress, low-income people may be limited to one or two low cost plans. The Philadelphia experience tells us that this could be dangerous. Maxicare was a successful bidder to run HealthPass in 1986. It went bankrupt in 1989, causing serious disruption in health care to our clients. It hurt three different segments of the community. It hurt our clients, who were unable to find hospitals, pharmacies, and physicians to care for them. It hurt providers who wound up advancing care and not getting reim-

bursed for it, and it cost the State, which wound up then having to pick up the cost of people who are left out in the cold, find care for them, and pay money for care and services that it already paid for in advance under its capitated rate.

That leads to the second point which is that strict oversight of managed-care networks is critical. As the GAO reported to this subcommittee back in December, there is a lack of standards for State insurance departments monitoring health plans. Oversight and particularly oversight of the fiscal matters with respect to plans is even more critical when you are dealing with a capitated program whereby bankruptcy would mean that patients are forced to change providers of health care.

Next, there must be independent public accountability of managed health care. The HealthPass program was not required to obtain an HMO certificate of authority or a license in Pennsylvania in order to operate. That meant that the State Department of Public Welfare selected the contractor, paid for the care and services, and oversaw its quality and accessibility.

We are always concerned when the same agency that pays for the care also is charged with judging its performance. There may be a tendency to judge quality and accessibility with a less critical eye, especially in times of a tight budget. We came to learn at HealthPass that despite a congressional mandate to expand the availability of treatment for children through OBRA 89, HealthPass statistics showed that only 1 in 3 of eligible children were undergoing the critical EPSDT screens, and when the Joint Commission on Accreditation of Health Care Organizations reviewed the program's quality assurance systems, they, too, were found deficient.

Let me conclude by pointing out one of the other problems that we have had, faced most recently, and that is the dispute that has occurred between the children's hospital in Philadelphia and the HealthPass program. It points out the problem when HealthPass has all the patients, the hospital has all of the critically needed services, the two are at loggerheads, suing one another, patients have been told they need to find other care, their families are required to change physicians, it has been an entire mess.

Once again, the problem of forcing folks in without giving them an option is something that the Congress desperately needs to guard against. I thank you.

[The prepared statement and attachments follow:]

**TESTIMONY OF MICHAEL J. CAMPBELL
PENNSYLVANIA HEALTH LAW PROJECT**

Good morning, Chairman Stark and members of the Subcommittee. My name is Michael Campbell. With me is Ann Torregrossa. We are attorneys with the Pennsylvania Health Law Project (PHLP) in Philadelphia. PHLP is a non-profit, legal services program that specializes in health law impacting on low-income Pennsylvanians. In this capacity we have been very involved in the issues surrounding the Philadelphia HealthPass program, the state's Health Insuring Organization (HIO).

Healthpass was created in 1986, pursuant to a federal waiver that permitted the State of Pennsylvania to require 100,000 Medicaid recipients in Philadelphia to receive their health care from a managed care network. Low-income people were very quickly herded into a managed care system with the promise that they would receive better care, whereas the primary motivation was the need to achieve savings immediately to balance the state budget.

We think that many of the same forces are at work in the national health reform debate as were behind the birth and development of HealthPass. Our Philadelphia experience has provided us with some hard-learned lessons that we would like to share with the Subcommittee. It would be a shame to make the same mistakes twice.

Here are some things we have learned:

1. It is dangerous to put all of your eggs into one basket.

Under many of the plans before Congress, low-income people may be limited to only one or two low cost plans. The Philadelphia experience tells us that this can be dangerous. Maxicare was the successful bidder to run HealthPass in 1986. It went bankrupt in 1989, causing serious disruption in health care for our clients. From one day to the next our clients did not know if they were covered. They were turned away by hospitals, pharmacies, and doctors' offices. Today, five years later, issues of payment to hospitals and other providers have not been resolved.

The Maxicare failure was harmful not only to low-income consumers who had been forced into HealthPass, but also to the health care providers who served the poor. (See attached Philadelphia Inquirer article, January 25, 1990, "Ex-HealthPass Operator's Plan Offers 25 Cents on Dollar.") And it might still cost the government additional money for care already purchased before the plan failed. (See Philadelphia Inquirer article, January 5, 1990, "HealthPass Snarl Will Cost State an Extra \$1 Million".)

2. Strict oversight of managed care networks is critical.

It took a massive state effort to monitor the HealthPass program just to make sure that care and services were not worse than under Medicaid fee for service. Clearly, when you move to a system which provides financial rewards for underservice, but which locks patients in so that they cannot "vote with their feet" by switching out, strict oversight is necessary. Despite their efforts, state officials still didn't know what was going on with respect to fiscal issues.

3. There must be independent public accountability of managed health care.

The HealthPass program was not required to obtain an HMO certificate of authority, Pennsylvania's equivalent of a license, from the state Department of Health. This meant that the state Department of Public Welfare (DPW): 1) selected the contractor, 2) paid for the care and services, and 3) oversaw its quality and accessibility.

We are always concerned that when the same agency which pays for care also judges its performance, there may be a tendency to judge quality and accessibility with a less critical eye, especially in times of tight budget. DPW personnel had no experience in overseeing a managed care system, and did not want to be criticized for making a bad selection. So we came to learn that despite a congressional mandate to expand the availability of treatment for children through OBRA '89, HealthPass statistics showed that only one in three of its eligible children were undergoing EPSDT screens. And when the Joint Commission on Accreditation of Health Care Organizations reviewed the program's quality assurance systems, they were found deficient. (See Philadelphia Inquirer article, July 29, 1990, "HealthPass Firm Faulted on Quality Controls.") Managed care programs must have treatment protocols and other quality assurance mechanisms in place at the time they begin to serve patients, and these systems must be subject to independent review.

4. Health plans need a great deal of time to set up systems if consumers' interests are to be protected.

After Maxicare failed, the HIO contract went to HMA, a new enterprise created exclusively to respond to the bid. HMA had no systems in place. They were not required to demonstrate proper credentialing, adequate numbers of providers, effective grievance procedures, fair marketing methods or the like before they were permitted to accept enrollees.

The following is one example of the kind of snafus that occurred: recipients were forced to pick a physician from lists thrust at them in the welfare office. Anyone failing to pick, was assigned a physician. You can imagine what it would be like if I simply handed you a list and asked you to choose a doctor. Imagine what a severe hardship it was in a multilingual area with a high degree of illiteracy such as Philadelphia. On the other hand, it took over a year before the doctors got their list of patients. The bid called for monthly enrollment lists going to the doctors, but HMA had no system to accomplish this task.

5. Awarding managed care contracts with guaranteed numbers of locked-in members allows the government to give a for-profit corporation a monopoly, subject to abuse.

In Philadelphia right now, there is a huge dispute between HMA and Children's Hospital. These two corporate titans have sued each other for everything imaginable. Both are using very ill low-income children as their pawns in this corporate battle over health care profits. (See Philadelphia Inquirer article, September 4, 1993, "Needy in Middle of Health Dispute.")

There is also the opportunity for favoritism in contracting and subcontracting. (See Philadelphia Inquirer, article, May 5, 1990, "Friend of White's Has Stock in a HealthPass Company.") The five year contract awarded by Welfare Secretary White to HMA was the subject of a critical report by the Inspector General's Office of HHS because of a friend's ownership interest in the company. In the area of subcontracting, there were allegations that HMA gave very lucrative contracts to friends for both the insurance and prescription processing aspects of the HealthPass program.

These are the sorts of problems that you foster when patients have no viable alternative. Ironically, the savings to the government which everyone expected may not actually occur. In six years the HealthPass premium increased from \$90.50 per person to \$213.50 per person, per month. This was an increase of 137%. (See Philadelphia Inquirer article, November 10, 1992, "HealthPass Premium Has Gone Up 11.5%.")

6. Managed care has not resulted in high quality care for low-income people.

The HealthPass program claims that care has not gotten any worse than fee-for-service for those low-income people in Philadelphia enrolled in that plan. It is true that it could hardly be worse. The ability to link some patients to a primary care doctor, and the ability to identify specialists for some patients, has led to decreased dependence on emergency rooms for care. This improvement was welcomed by all. But our colleagues in the mental health field and those who assist clients who carry the HIV virus tell us that access to treatment in those areas has gotten worse. And one study showed that less than a third of recipients receive adequate and verifiable pre-natal care. (See Philadelphia Inquirer article, November 10, 1991, "Report: HealthPass Cost is Far More than Expected.")

The mainstreaming of care for the poor, so important to quality care, which Congress envisioned when it imposed the 75%-25% rule, doesn't exist within the HealthPass program. And if we can digress from HealthPass for a moment, we would like to point out that it doesn't exist for some other HMOs serving Medicaid patients either. They have successfully evaded the requirement by using a Blue Cross plan as a cover. In aggregate, they meet the percentage requirement. But in operation, they are totally segregated.

7. While managed care may not have improved care for low-income people, it certainly has improved profits for some well-connected corporations.

Federal auditors found that HMA's owners have been getting an average return of more than 3,500% on their original investment of \$200,000. HHS conducted an audit of HealthPass and found that the company is in "imminent danger of becoming a cash cow." (See Philadelphia Inquirer article, November 22, 1991, "Audit Assails HealthPass Profits.")

Our point with respect to profits is that when you set up a system which provides a financial incentive to cut corners on the delivery of care, the public must be protected from overreaching. The Medicare program has a requirement that at-risk HMOs return excessive profits either to the government or to the beneficiaries by way of increased benefits or reduced premiums. We suggest that the concept is a good and necessary one which could be adapted to fit any managed care plan.

8. Solely switching to managed care is not the real reform we need in America.

The substance of this testimony may suggest that we oppose all managed care. On the contrary, our client groups have been fighting for a managed care option for the poor for more than a decade. During the mid 1980s, our state's Medicaid advisory committee passed a resolution urging that all managed care programs within the state be required to participate in the Medicaid program. The operative word here is "option." We continue to have serious problems with mandatory managed care programs for the poor, and we hope that our testimony has helped to identify some of the pitfalls of such an approach for the Subcommittee.

Conclusion

In conclusion, we urge the members to support real reform, not just more people in managed care. We believe that both accessibility to quality care and the savings that our health care system need depend on an affordable, universal health care system with public accountability.

Ex-HealthPass operator's plan offers 25 cents on dollar

By Walter F. H. Jr.
Hospitals, physicians and other providers of health care would get under 25 cents for every dollar owed under a new plan that would be the bankruptcy of the HealthPass program.

The reorganization plan filed recently in court in San Antonio, Tex., would allow the operator of the HealthPass program to pay back its creditors when paid off — could boost the program to a maximum of 50 percent of the amount owed, according to Lawrence G. MacVicar, an attorney representing the plan.

MacVicar, which filed for bankruptcy nearly a year ago, operated the HealthPass program through a subsidiary, HealthPass Inc. The plan would provide a maximum of \$10 million in reimbursements to the plan. The plan would be the result of a recently completed analysis of the plan.

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HealthPass premium has gone up 11.5%

A DPW aide said the fee was cut from \$191.50 to \$180.22. Actually, it rose to \$213.50.

By Walter F. H. Jr.

A state official said yesterday that earlier reports of a rate decrease for the HealthPass program were in error and that payments this year have actually increased by 11.5 percent or about \$24 million annually for the state Department of Public Welfare.

Said the official, the state will pay each of the 81,000 HealthPass recipients was recently adjusted to \$213.50. That increase, implemented in September, came on top of an increase to \$209.41 in the summer before the two recent increases.

PHILA. INQ. 1-25-90

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HealthPass premium up 11.5% in 1992

Increases in medical costs experienced across the state and country.

Established in 1986, HealthPass serves low-income residents of South and West Philadelphia. The original monthly payment rate for each recipient was \$99.50, less than half the amount firm has made in high profit from the program, a charge seriously denied by the state and HMA.

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PHILA. INQ. 1-25-90

SATURDAY
May 6, 1990

□ BUSINESS, on 6-B

Friend of White's has stock in a HealthPass company

By Walter F. Ruck Jr.

In an apparent contradiction to assertions by State Public Welfare Secretary John F. White Jr., a close friend of White's is a stockholder in the parent company of a firm that has a major contract for the HealthPass program.

HealthPass is the owner of the program's benefit services (CSCS) of Elixia. CSCS has a contract valued at about \$1 million per year to process all pharmacy claims for the 82,000 HealthPass participants who reside in South and West Philadelphia. HealthPass is a \$1.6 billion-a-year health program administered by the state Welfare Department.

White said Tuesday that White retained continued that Duggin had made no financial gain from the contract, "except whatever" White might have been paid by Duggin on the sale of his financial interest, the said the secretary did not wish to be interviewed on the subject.

There is nothing more to say about it," he said. Duggin himself has remained available for comment. Duggin's stock ownership was acknowledged in an April 19 letter from CSCS executive vice president

Denis M. Ryan to White. Ryan had earlier said Duggin's stock represented "not more than twenty or twenty-five percent" of the parent company. Overall, Employee Benefit Plans has about \$1 million outstanding stock, Ryan said on the letter.

Any suggestion that Mr. Duggin benefited financially from CSCS in connection with a HealthPass subcontractor due to the fact that he is a shareholder in EBP is merely groundless and without merit. Ryan said.

Friend of White's owns stock in subcontractor

HEALTHPASS, from EBP, in the letter to White. Stating that the HealthPass subcontract represented less than 1 percent of the projected revenue and profit for Employee Benefit Plans, Ryan said the impact of the contract on the value of Duggin's stock was "so negligible as almost to be nonexistent."

According to records filed with the Securities and Exchange Commission, Employee Benefit Plans had 6,341,415 shares of stock outstanding early this year and those shares were held by 1,165 stockholders. According to over the contract stock reports, the value of 10,000 shares in Employee Benefit Plans was \$167,500 as of Monday.

In a decision that has generated considerable controversy, White last year awarded a five-year contract to run the HealthPass program to a new firm called Healthcare Management Alternatives. That company subsequently contracted with CSCS to process all pharmaceutical claims for the 82,000 HealthPass program participants.

Under the contract, a copy of which was obtained under the federal Freedom of Information Act, CSCS is being paid \$1.22 for each HealthPass prescription claim processed. HealthPass participants are expected to generate about one million prescription drug claims per year.

HealthPass is a prepaid managed health program that operates under special waivers from the U.S. Department of Health and Human Services. According to Securities and Ex-

change Commission records, Duggin became a stockholder in Employee Benefit Plans in late 1986 when he and two other stockholders in CSCS sold out to EBP. Duggin, according to those filings, was paid \$383,161 in cash plus 104,400 shares of Employee Benefit Plans. Overall, according to the Securities and Exchange Commission filings, Employee Benefit Plans paid out \$1,186,667 in cash and \$1,309,000 worth of stock to purchase CSCS. In addition, according to the SEC disclosures, the former CSCS shareholders were given notes valued at \$172,000.

Duggin, according to the SEC filings, got \$32,610 worth of those notes at the time of the sale. In addition, according to SEC filings, under an agreement between Duggin and Employee Benefit Plans, Duggin could become retroactively eligible for certain option plans (normally reserved for employees) based on new business that Duggin helped generate for either CSCS or its parent company. According to the agreement, Duggin would become eligible for the added benefits if business increased beyond certain levels.

The Healthcare Management Alternatives contract has been the subject of critical audit reports by the Inspector General's Office in the U.S. Department of Health and Human Services. As a result, Health and Human Services refused to approve the \$750.7 million pact in its original form.

State officials have agreed to cut the contract from five years to two and to make a series of other changes.



John F. White Jr.
Has said pact didn't benefit Duggin

some of which have yet to be finalized.

Duggin also has business ties to Anthony Welles, the head of Healthcare Management Alternatives, the firm with the HealthPass contract.

White has vigorously defended the Healthcare Management Alternatives contract and the process that led to the selection of the firm. "HMA was awarded this contract," said White recently, "because they were indeed the best company to do the job."

HealthPass firm faulted on controls

The car race is the most expensive awarded in the state, expected to total over \$1 billion.

Two studies have shown that the use of HMA in the construction of roads can reduce the amount of greenhouse gas emissions. The first study, by the University of California, Berkeley, found that the use of HMA in the construction of roads can reduce the amount of greenhouse gas emissions by 10-15% compared to the use of concrete. The second study, by the University of Texas at Austin, found that the use of HMA in the construction of roads can reduce the amount of greenhouse gas emissions by 10-15% compared to the use of concrete.

The commission's preliminary staff report has not been made public, though it has been in the hands of state officials for about three weeks. Last week, State Welfare Secretary John F. Winger announced he had picked H&M over three other firms to run the bid for the next five years. Winger at that time praised H&M for its sample grants since taking over the program in 1982. "Healthcare is a pilot program providing for the care of persons about \$2,000 a month, regardless of their

DOI: 10.1111/j.1365-2231.2012.01750.x

*U.S. calls
it a future
cash cow*

[illegible]

The following table shows the number of persons who were employed in the various occupations in the United States in 1900, and the number of persons who were employed in the same occupations in 1910. The figures are given in thousands of persons.

The backstop

The primary underlying principle of an enterprise's internal controls is that the more sophisticated programs such as multi-layered firewalls and intrusion-detection capabilities are only a partial solution. Such programs agree with the notion that the most effective defense against a host of security issues is a combination

According to the revised MTA, a transportation investment bank of \$1.5 billion. The monies are allocated to MTA's two major capital projects in its 11 counties as follows, whereof \$1.1 billion has been used as earnest money:

- \$100 million for the new expansion of the Washington Metro system, with the Metropolitan Police, with over 50 police officers MTA, to be expanded to provide additional security.
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the mechanism of the reaction between the two species. The authors conclude that the reaction is a bimolecular process, the rate of which is proportional to the product of the concentrations of the two species.

\$17 million in 'bonuses'

In addition to the payments to Jamil and Hussein, the report said, a limitation was paid of more than \$10 million to four directors of the company.

Other payments, the report says, included more than \$1 million to management, including past Atlantic Systems and now current

According to the report, 134 chief financial officers don't respond to a request for a breakdown of the questions that are being asked, although what services are used do not seem to be the main concern.

The authors questioned the value of such management fees with S&P's already spending more than \$500 million per year in salaries for top executives. Savings for top executives could reach up to \$42 million.

Still other payments questioned are the audit fees paid to Arthur Andersen, PricewaterhouseCoopers and Ernst & Young and others. The audit fees for S&P's are credited to the S&P's. The Lower tier is nearly \$300,000 in payments to its main raters.

A confidential federal report has concluded that the HealthPass program has generated "vast amounts of money" for the company running the program, and is in "imminent danger of becoming a cash cow." In a highly critical report, Gerald Kalafatis, the regional inspector general for audits in the U.S. Department of Health and Human Services, concludes that the HealthPass management firm, Healthcare Management Services, had not carried out its mission during its first 18 months in existence more than three times the \$44 million HHS recorded on its financial records as after-tax profits.

According to the eight-page report, TMA's records show a pretax profit of \$9,688,290.

On top of that, the report states, the owners of HMA and affiliated companies got \$2.5 million in interest-free "advances" from HealthPass, of which \$2.2 million had not been paid back as of July 26.

According to the report, HIMA's chief financial officer declined to respond to a request for details on many of the questions Rafalick raised and HIMA yesterday did not respond to requests for an interview.

The report, however, does include a five-paragraph response from the state Public Welfare Department, which defended UIMA's contract and said that regardless of profits, the company had saved the state and federal government about \$55 million.

The state also noted that some of the profits — up to \$3 million of the \$16.6 million — had been rechanneled into community programs, including a health clinic at the Saltzberger School in West Philadelphia. State officials also noted that IMA won the contract through competi-

The federal auditors nonetheless found that HMA's owners have been getting an average annual return of more than 1,500 percent on their original \$200,000 investment.

HMA, at 50th Street and Parks Avenue in West Philadelphia, took over HealthPass on July 1, 1989. The six-year-old demonstration program provides health care to 80,000 low-income residents of South and West Philadelphia.

In our opinion, the recorded net earnings are extremely misleading and completely overstate the vast sums of money made by IMA owners, directors and affiliated companies from the HealthPlus contract.

The New \$ report, which was addressed to another Health and Human Services regional official, Maurice Hartman, concluded the healthplan is generating unreasonably high returns for JMA's owners.

It was not the intent of federal officials, and we believe it was not the intent of the state, "that our healthplan contract become a case

HealthPass

the 1990s, the number of people in the world who are illiterate has increased from 1.2 billion to 1.5 billion. The number of illiterate people in the world is expected to increase to 1.8 billion by the year 2015. The number of illiterate people in the world is expected to increase to 2.1 billion by the year 2025. The number of illiterate people in the world is expected to increase to 2.4 billion by the year 2035. The number of illiterate people in the world is expected to increase to 2.7 billion by the year 2045. The number of illiterate people in the world is expected to increase to 3.0 billion by the year 2055. The number of illiterate people in the world is expected to increase to 3.3 billion by the year 2065. The number of illiterate people in the world is expected to increase to 3.6 billion by the year 2075. The number of illiterate people in the world is expected to increase to 3.9 billion by the year 2085. The number of illiterate people in the world is expected to increase to 4.2 billion by the year 2095.

Report: HealthPass cost is far more than expected

By Walter P. Roche Jr.
Special Staff Writer, *Philadelphia Inquirer*

An interim report by the federal government has found that the costs of the HealthPass program have been substantially underestimated and a retroactive rate increase of 9.2 percent, or \$11.6 million, appears likely. The report, prepared by the U.S. Department of Health and Human Services, also concludes that while HealthPass has had a generally favorable impact on its 82,000 recipients, there were major gaps, at least initially, in quality-assurance efforts by the program operator.

HealthPass, funded by the state and federal governments, provides medical care to low-income residents of South and West Philadelphia. The

state pays a private firm a fixed monthly fee for each recipient and the firm then subcontractors with physicians, hospitals and other providers.

The 25-page report was the result of an on-site review of the operations of Healthcare Management Alternatives (HMA), the program administrator, by federal officials in July and August. The periodic assessment report is required because HealthPass is a pilot program operating under special waivers from the federal government.

HMA officials said they had not been provided with a copy of the report and complained that it had been released by state officials before. (See HEALTHPASS on 4-B)

HealthPass costs high, report says

HEALTHPASS, from its first year, had a chance to make a formal report.

The report also states that:

• The number of physicians and other health-care providers participating in HealthPass far exceeds the maximum federal standards.

• While a "high level" of services was available to recipients, less than half the patients in the program for six months or more had an appointment with their physician.

• A review of physicians' care being provided in practice showed over half of the physicians surveyed had completed forms for accreditation levels, with some scoring low as 20 percent.

• Less than one-third of the recipients who gave birth in a six-month period had received adequate and verifiable prenatal care.

• Quality assurance committees met irregularly and did not document their efforts.

• Though costs have exceeded its major objectives, HMA has succeeded in reducing overall costs when compared with the regular Medicaid assistance program.

Among the recommendations in the report are an increase in staff to monitor HealthPass and more detailed data collection and review by the state on an ongoing basis and to pay health care claims. The reviewers found the balance in the program account should be kept at the minimum level and state officials authorized a \$2-million distribution to HMA in July.

According to the report, the program's success in paying claims will be necessary because the current level of payments is only a fraction of the cost for the regular Medicaid program. Under circumstances with this, the HMA's payment rate is based on a percentage of regular Medicaid costs.

Under the terms of the state-begging March 1, 1980, monthly payment to HMA for each recipient from \$149.5 to \$193.5. That in excess, however, was paid as a lump sum and not to be used for HMA the report stated, already has adjusted its books to reflect a reduction in cost of \$140 per month or 25.4 percent over the original rate.

According to the report, state officials agree the fees must be increased retroactively but the exact amount will not be computed until after the current contract runs out Dec. 31.

Like the state, HMA also undertakes in its contract the federal reviewers concluded during that payments to health care providers during the first eight months of the current contract totaled less than \$22 million over HMA's estimate.

The reviewers' findings could not determine whether the firm actually made a profit during that period. However, the report calculates that "there is a fairly good probability" HMA will make a profit for the 10-month period ending Dec. 31, largely because of the retroactive adjustment.

12-B Friday, Jan. 12, 1989 The Philadelphia Inquirer

Judge orders review and payment of contested HealthPass claims

By Walter P. Roche Jr.
Special Staff Writer

Philadelphia area health-care providers may soon be able to recover up to \$7.1 million owed them for services provided under the HealthPass program to low-income, low-income South and West Philadelphia.

The money, now in a trust account in a Philadelphia bank, could begin flowing within two weeks under an order entered by a federal bankruptcy court judge in Philadelphia after this week's members of a HealthPass advisory board were told during a monthly meeting yesterday.

Lorena McLaughlin of the Delaware Valley Hospital Board said the court order set up a mechanism and procedure for reviewing and paying the claims. Under the order, the first set of checks is to be issued by a Jan. 26 deadline.

The former HealthPass contractor, the Penn Health Corp. had requested in the claims contesting the report, about \$100,000 in costs. Penn Health's parent company, located in Maryland, filed for bankruptcy in March.

The ruling applies to services provided to HealthPass clients during a four-month period ending June 30, 1988. Today, Penn Health's contract expires. J. Healthcare Management Alternatives (HMA), a new firm, took over the program July 1.

Lorena McLaughlin said the plan for area hospitals and other pro-

viders in the bankruptcy case said it was "probable" that a large percentage of the pending claims would be approved under the new procedures. HMA and Medicare had agreed to send auditors to Philadelphia to review the claims. The providers include not only hospitals but pharmacies, physicians and home care agencies.

The \$7.1 million is but a fraction of what local health-care providers claim from the Penn Health firm. An additional \$20 million is being sought for services provided prior to the filing of the bankruptcy petition. McLaughlin said the court had not yet ruled on how these claims would be handled.

During yesterday's advisory panel meeting, McLaughlin also urged state welfare officials to inform all HealthPass providers of the court ruling and steps needed to assure reimbursement. Only 52 of the more than 300 providers were formally represented in the California court hearings.

Deputy Welfare Secretary Eileen M. Schoen also told the committee that final details were still being worked out to settle a dispute between the state and federal govern-

ments over the new HealthPass contract. The federal government initially had refused to approve the contract because it contended that the state had shown favoritism to the winning firm.

Under a preliminary agreement reached in December, state and federal officials agreed to work out amendments to the contract by Jan. 10.

Schoen said she expected a final agreement by early next week. Responding to committee questions, she said she did not yet know whether the contract changes would increase state costs.

After the meeting, McMichael said hospital representatives were "disappointed and displeased" that the agreement had not been finalized by the deadline. "It should have been resolved quickly," he said.

Schoen, the deputy welfare secretary, also reported that her agency was gearing up to solicit proposals for a new HealthPass contract to be gone effective Jan. 1, 1991.

Saying that she was concerned about the tight timetable, Schoen said the department was trying to get out specifications for the bidders as soon as possible.

Metro

Saturday, September 4, 1993

Paying tribute to the man
who gave them Labor
Day, B3.

Automotive, B4.
Weather, B7.

Needy in middle of health dispute

Children's Hospital sued
the manager of
HealthPass, first
millionaire health care
network, lawsuit mark

By Robert J. Kohn

When a child is in the middle of a health dispute, the parents are often the ones who are in the middle of a dispute.

The lawsuit filed by Children's Hospital of Philadelphia (CHOP) against the manager of HealthPass, a first million-dollar health care network, is a landmark case in the history of the network.

The lawsuit, filed in the U.S. District Court in Philadelphia, alleges that the manager of HealthPass, a first million-dollar health care network, has been negligent in his duties.

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Needy in middle of conflict

HEALTHPASS, a first million-dollar health care network, is in the middle of a conflict with Children's Hospital of Philadelphia (CHOP). The lawsuit, filed in the U.S. District Court in Philadelphia, alleges that the manager of HealthPass, a first million-dollar health care network, has been negligent in his duties.

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HealthPass snarl will cost state an extra \$1 million

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4.B Friday, Aug. 5, 1993 The Philadelphia Inquirer

The Philadelphia Public Welfare Department (PWD) is in the middle of a conflict with HealthPass, a first million-dollar health care network. The lawsuit, filed in the U.S. District Court in Philadelphia, alleges that the manager of HealthPass, a first million-dollar health care network, has been negligent in his duties.

Chairman STARK. Thank you very much.
Ms. Johns.

**STATEMENT OF LUCY JOHNS, M.P.H., SAN FRANCISCO, CALIF.
(INDEPENDENT CONSULTANT, HEALTH CARE PLANNING
AND POLICY)**

Ms. JOHNS. Thank you, Mr. Chairman, Representative Johnson. My name is Lucy Johns. I am an independent health policy expert working for some 19 years out of San Francisco with many levels of Government, the old health systems agencies, self-insured firms, private foundations, and the more progressive sort of providers. I also sit as the only nonacademic on the Faculty Council of the School of Public Health, University of California Berkeley, and publish as often as I can in Health Affairs, for example. I am here today to alert you to a small but vital element of the President's Health Security Act, which addresses a problem that can arise in health service delivery systems operating in a highly competitive environment like northern California. This element is the inclusion of obstetrics-gynecology as a specialty providing primary care. That is in title III, section 3012(e).

What we now see in northern California is the big HMOs—TakeCare, QualMed, Health Net—California Care, to mention a few, decreeing that obstetrics-gynecology is not a primary care specialty, and that ob/gyns are not primary care physicians. So if you are a female member of one of these plans and you are used to seeing your ob/gyn once a year for your pap, breast exam, birth control counseling or for older women your mammogram referral or report, you find that you can't get there without getting a referral from an internist or family practitioner, who may be financially penalized for such a referral. This pattern makes me wonder and should make you question whether marketplace incentives alone under managed competition produce adequate care for women.

There are three reasons to be concerned about barriers to access to ob/gyns for preventive gynecological or obstetrical services.

First is the training that internists and family practitioners get in these vital areas of women's health. For residents in internal medicine there is a requirement concerning office gynecology which should be available, but its duration and content are unspecified. In family practice there is a required 3-month rotation that includes 1 month of gynecology and two of obstetrics plus, under a subject called "elements of family care," some training in human sexuality and family planning. Residents in ob/gyn by contrast spend time in every rotation over 4 years learning to prevent and when necessary to care for the unique problems of women in the ambulatory setting.

The second reason for concern is the services that ob/gyns, internists, and family practitioners actually end up providing to women. A study published last year in the New England Journal of Medicine measured the frequency of preventive ob/gyn services provided by these three types of physicians in a major HMO in the Twin Cities. Ob/gyns, regardless of their age, their sex or the age of their patients, delivered preventive services with far greater frequency than did the internists or the family practitioners. These services

that they provided—Paps, breast exams, et cetera, are not frivolous, unnecessary or merely comforting. They can save lives.

The third reason may not seem as compelling, but it is still worthy of mention. Historical data from Federal surveys on use of ob/gyns by women unconstrained by barriers to access from 1973 to 1990 showed that nearly a third of visits to all physicians by women 15 to 44 were to ob/gyns and that 95 percent of these visits are self-referred, suggesting a strong preference. It is interesting to note that in southern California the needs and preferences implicit in the Federal data are taken as a mandate to enable unrestricted access to ob/gyns as primary care physicians. But not in northern California.

Whatever the reasons for this exclusionary trend, it reveals the need for attention to issues of delivery system design. In any proposal for health system reform, whether under managed competition, single payer, small market insurance reform or even old-fashioned rate regulation, health plans and their physician components will bear increasing financial risk. Creative responses to new limits on income will evolve, including controls on access to both primary care and specialist physicians. Suppose the patient wants to see a physician? The plan may present a physician's assistant or a nurse practitioner. Suppose the patient wants to see an orthopedist? The plan may offer a general surgeon. Suppose an adolescent wants to see a "grownup" doctor? The plan may require a pediatrician. Decisions about who does what to whom in plans will be made, are being made, far from public scrutiny of any kind. The exclusion of ob/gyns as primary care physicians in some large HMOs shows the potential impact of delivery system design decisions on patients.

Now, some may argue that the market constitutes a natural corrective here. If women join a plan that prevents their seeing an ob/gyn without a referral and they are unhappy with this to the point of switching plans, the first plan will change its delivery design. The problem with this remedy is that response time will be slow and rivalry among different physician specialties may muffle sensitivity to women's complaints.

Concern for women's health is at an all time high. Placement of barriers between women of reproductive age and the specialty dedicated exclusively to their health care highlights delivery system design as a central issue in health care reform. Primary care for women is too sensitive a feature of managed care to be left by policymakers entirely to the mercy of the market. The Clinton proposal at least begins to address the problem by defining ob/gyns as primary physicians for medical education purposes. There are other points in the bill where the status of ob/gyn as a primary care specialty could be protected. Please make certain that obstetrician-gynecologists remain available to women seeking this type of physician to provide for their primary care needs. Thank you.

[The attachment to Ms. Johns' statement follows:]

APPENDIX TO TESTIMONY OF LUCY JOHNS

INTRODUCTION

The managed care market in California, for a decade a maelstrom of creative adaptations to the selective pressures of competition, shows a new pattern of interest for designers of health reform proposals: small area variation among plans in their selection of primary care physicians (PCP). In major HMOs in the northern California urban markets of Sacramento and the San Francisco Bay Area, obstetrician-gynecologists (ob-gyn) have virtually disappeared as PCPs available to patients. Of course, experimentation with provision of primary care has a long and honorable history, including use of non-physician practitioners and advocacy of self-care. This particular variation, however, is inconsistent with state policy, contrary to historical preferences of those most in need of ob-gyns' services (females of reproductive, age 15-44), and unsettling in light of recent studies related to quality of care. In short, it raises issues that merit more public scrutiny than hitherto applied.

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DISCUSSION

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At least three factors constrain a rapid market response to the issues raised by exclusion of ob-gyns from PCP status. Foremost is the conviction among some physician group managers that care provided by ob-gyns is expensive compared to that available from FPs or internists. This belief encompasses both patterns of practice and the cost to the plan of fees or salaries. Concerning patterns of practice, there is no published information¹⁹ and if there were, it would not necessarily apply within a managed care setting. As for the cost of ob-gyns compared to other specialists, there is no excuse for failing to test the possibility that in a competition for PCP status, the price demanded by ob-gyne for their labor will decline. Such competition might also serve to dampen the price for FPs, currently soaring in response to a perceived "shortage."²⁰

The second factor is the distraction created by the clamor of other specialties for recognition as PCPs.²¹ Physicians in physical medicine, rehabilitation and emergency medicine are also seeking a primary care role.²² Physician group managers and other can cite clinical specialization as an easier guideline to follow in choosing PCPs than the actual content of care provided by individual clinicians.

The third factor inhibiting a market solution to exclusion of ob-gyns as PCPs must be acknowledged, namely, division within the specialty on the desirability of such status. Many ob-gyns have functioned and perceive themselves as referral surgeons and sub-specialty consultants (in infertility, for example). Their training aims to prepare them as "providers of primary care to women"²³ and the American College of Obstetrics and Gynecology (ACOG) has issued practice guidelines on "primary-preventive care."²⁴ The market, however, has rewarded ob-gyns who prefer a more restricted role. The physician managers now designating the PCPs bring this stereotype of the ob-gyn to the present task and use it to dismiss ob-gyns now seeking PCP status. These ob-gyns face hostility not only from rival specialists in managerial positions but also from ob-gyns resisting changes implicit in managed care.

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REFERENCES

19. Some pertinent but proprietary data are now being collected. For example, King County Medical Blue Shield (Seattle) has a claims-based data system that shows resource use by practitioner and patient problem. Presentation by T. Rogers, Senior Vice President for Medical Affairs, KCMBS, at the National Health Policy Forum, Washington, D.C., June 1993.
20. Boughton B. Primary care's new power. Northern California Medicine 1993; 41:1,7. This power will be tested to raise fees. For example, the President of the California Academy of Family Practice declared in 1992: "...for the primary care physicians [i.e. FPs] who are out in rural areas... doing the surgeries and the caesarian sections... cholecystectomies and bowel resections and mastectomies... I think they [HCFA and other payers] are going to have to look at that." Interview with Mary E. Frank. Northern California Medicine 1992; 3:9.
21. We do not even address the possibility of physician substitutes. The American Nurses Association maintains that some half million of the two million registered nurses in the U.S. could be trained to provide "the same" primary care that physicians do within "12-18 months." Inside Health Care Reform 1993; 1:3.
22. Federal law pertaining to medical student loans lists "family medicine, general internal medicine, general pediatrics, preventive medicine or osteopathic general practice" as primary care specialties (P.L. 102-407, Sec.723(d), October 13, 1992). Draft regulations were criticized not only by the American College of Obstetricians and Gynecologists but also by specialists in physical medicine, rehabilitation and emergency medicine (Fed Register 1993, 58:37494).
23. Directory, p.70.
24. Primary Care Preventive Health Care Task Force. The role of the obstetrician-gynecologist and primary - preventive care. Washington, D.C., American College of Obstetricians and Gynecologists, Washington, D.C., 1993 (draft).

Chairman STARK. Thank you. I thank the witnesses for calling to the committee's attention the need for some thorough review and perhaps expansion of the proposals in the President's bill for controlling, surveying and having oversight over managed-care plans.

Now, the President's bill is to be commended. Insofar as I know, it is the only bill that relies on anything except price competition in an attempt, I suppose, at education to deliver quality and reasonable care—and protect the consumers, the beneficiaries, but having said that, that is at best damnation by faint praise.

I have heard an awful lot about educating beneficiaries. Dr. Rowland, you indicate that it takes some effort to educate a beneficiary about how to use a managed-care system. Can you offer us any insight as to how well the low-income population understands procedures, how well they comply with them, what proportion of managed-care plans spend much effort to educate, and before you answer that, I think the Chair should state for the record that there are managed-care plans that try to do a good job, and they are not all crooks.

There are some who deny service and are in it only for the profit, I suspect, but that may be true of politicians, so that is not an exclusive sort of territory. Our concern here is how to make sure that we protect the beneficiaries, and I say that without reference to my question to you, Diane, but just in general that what we are trying to determine here are those areas in which we have strong indication—I won't use the word "evidence"—a lot of vignettes or anecdotal evidence that there have been people who have been denied or maybe through their own fault, maybe they are just too dumb like me to understand what kind of care they need. How big of a problem is it to educate beneficiaries?

Ms. ROWLAND. Well, when you talk to many of the large Medicaid programs that have been involved in managed care, they say that one of the most important investments they have to make is counseling first on selection of plans so that when beneficiaries are choosing plans they understand what they are choosing and that they are choosing a plan that doesn't allow them free use of emergency rooms or other kinds of clinics that they have typically gone to.

Michigan is probably engaged in one of the most thorough patient education approaches. They said that it takes a lot of up-front time at the welfare office level to counsel the patients on their choices and then for the plans to try and work with patients on how to use the managed-care system.

What you find in areas where people enroll quickly and don't know what their choices are is that they start going back to the old providers of care rather than to the providers in the managed-care network, and then if those providers see them, they are seeing them as uncompensated patients, not as Medicaid patients.

Chairman STARK. Would you suggest that you would be better off requiring a disinterested party to provide that education, and it probably would serve us well to allow the sellers of the plan to provide the education because they may not have the right incentives, would that make sense?

Ms. ROWLAND. I think there is probably two levels of education. In terms of helping people to choose between a managed-care plan

and staying in a fee-for-service plan, education is probably best provided by either the State agency or by an independent body other than the plans.

One of the early areas of great abuse in the Medicaid program was in the marketing of plans to beneficiaries, especially in California, but continuing in other places. But then within a plan, I think plans have to invest in providing a low-income population that is generally not very savvy about these newer models of care, information about how to use the care system. They need to try and re-orient them from the care patterns they have been using. So I think it is two levels of education that have to be done.

Chairman STARK. OK. Mr. Campbell, you suggest that we need oversight of these plans, that it is critical, and I think it is fair to summarize your comment that State officials don't really know what is going on.

Is that a fair summary of what your testimony is? If so, can you give us some indication of what you think we ought to do in terms of setting oversight standards and what we might write into law that could be applied as an oversight standard.

Mr. CAMPBELL. Well, Chairman Stark, let me start by saying that the Philadelphia experience was particularly disturbing in that not only did State officials generally have limited information relative to the financial circumstances, but, in fact, the Health Department which traditionally oversees quality assurance with managed-care plans had no responsibility for this Medicaid-only created system. But when you ask about standards, there are certainly standards out there now that we are looking at—NCQA, I believe, has prescribed standards. HCFA has recommended standards. I think we need to be looking at outcomes.

Just to bring up one specific, we need to be looking at outcomes in health care areas. We need to be looking at numbers of children being immunized. We need to be looking at numbers of screens particularly for the poor community for lead paint poisoning. Those are the sorts of things we need to be looking at in a general way.

Chairman STARK. Going on to Ms. Johns, who has some concerns, H.R. 3600 relies pretty much on consumer choice. I mean, it says put the per unit price on the rack and the consumers will pick the right plan. Is that going to be satisfactory for women, and also assuming that they happen to choose the plan that isn't right for them, what do you think about the idea of having them locked in to a plan for a year before they could back out and choose another plan? Do you think that might work a hardship?

Ms. JOHNS. In principle, one could argue that consumer choice is protective, but what we see in northern California is a choice among plans that have all made the same decision, so I would come back again to legislative policy concerning delivery systems.

Chairman STARK. Do they make that decision for competitive reasons?

Ms. JOHNS. I really don't know. I cannot tell you the history in each plan of how that came to be. All I can tell you is that if you look at the primary care physician lists of all these plans now, that is the way it is. That brings us to delivery system design issues, and I realize that Congress cannot be involved in every single de-

livery system design issue, but this is a big one, and that is why I wanted to bring it to your attention.

In terms of being locked in, I think it is very hard to opt in and out on sort of a monthly or weekly or even a quarterly basis. No one can administer a system like that, and somebody encountering a difficulty early in a year still has recourse within a plan, a grievance procedure or trying to change the primary care doctor or whatever, so I think a year is a reasonable amount of time for people to learn about their plan and try to learn how to use it, at the end of which they then have the option of leaving if they are really unhappy.

Could I make a comment on what you asked the gentleman to my left?

Chairman STARK. Sure.

Ms. JOHNS. It seems to me that the idea of States certifying health plans implies that all the States have the capability, knowledge, and wisdom to do this. I am not sure that is the case.

Chairman STARK. Oh, I agree.

Ms. JOHNS. Maybe as part of health care reform if we are encouraging something called a certifiable health plan, it makes sense to me that since many plans will be multi-State entities, and Americans move around a lot, maybe we should have Federal certification of plans.

Chairman STARK. I would be happy to share with you, although they have been much maligned today, it was GAO who did a study for us, and basically they concluded that precious few States do a very good job, with all due respect to our Insurance Commissioner who is running for Governor, but our State isn't much better.

We have not had a record of controlling insurance, much less health insurance, and Florida is the most miserable example, but California isn't far behind. There are other jurisdictions, the District of Columbia, where it is nonexistent. Yes, and there are some States who can't because they don't have the money, and won't because the legislatures are impacted by the political pressure of the people who are trying to resist the regulation, and I think you are quite right that there is no reasonable assurance, there is no role model of any State that does a good job of regulating that would give us any comfort level to suggest that other States would.

Hawaii has quite a good record, but the fact is that you may not duplicate that in South Dakota, and I don't know if we can leave that to chance, so I would agree with you.

I wanted to ask Ms. Dooha, you say that patients must be guaranteed a choice of provider without any obstacles to seeing specialists. Do you think we could write something like that in law? You don't want somebody trotting over to a radiologist for an MRI every time that they feel they have a headache that might, in fact, have been tested thoroughly and they really just ought to stop eating extra pepperoni on their pizza, and to the best use of a managed care, they would perhaps direct people to a less costly care.

Now, that can be abused. Do you have any idea how we would pursue—or do you have any examples of a law or regulation that would leave reasonable access to these specialists, yet still allow the providers some chance to make good and to limit some of the abuse.

Ms. DOOHA. I understand what you are saying. Managed care is intended to reduce overutilization and bring about appropriate utilization of care. The problem comes when people with chronic conditions or disabilities, especially those who are medically fragile, must receive care from providers who are not knowledgeable about their specific care and must receive preventive care which involves tests, which involves scrutiny of their condition, which involves consistent communication and monitoring. It is critical that this care be provided by a care giver who is knowledgeable about their conditions.

In some instances that needs to be a team of care givers; for some medically fragile people, that is the way that care is coordinated now. It isn't that there is an absence of care coordination in the world, in the United States today. One might look at the MS care coordinated centers, hemophilia centers, AIDS centers, transplant centers as models of care coordination for people with disabilities.

The only regulation that I am familiar with is in California, and I will make that citation available to you, which would allow people under certain circumstances with chronic health needs to continue to see providers with whom they have an established relationship, and there have been some other proposals made which I could also make available to you, that would enable people to continue relationships with existing care givers.

We think we should go a step further and say that where there is a chronic condition or disability that requires care coordination by a specialist or by a team that that be available and that those essential providers who are there in the community should be accessible.

Chairman STARK. I agree. There is another problem. I have referred often to the Fort Lauderdale Sun Sentinel's November 11, 1993, 12-page summary of the horror stories of HMOs in Florida delivering Medicare, but I would refer to one because it is so easy to measure, and it is one that did catch my attention. A man named Howard Silver has prostate cancer, and he was able to be stabilized with a drug called Lupron, which cost \$350 a month.

Now, there was an alternative, and this HMO called CAC Ramsey, and Mr. Silver's doctor demanded a more—and this is a quote of the doctor, "cost-effective solution," and that was surgery to cut off Mr. Silver's testicles. Mr. Silver was not very enthusiastic about the alternate treatment, and he complained, and he says—they say that they have instances of HMOs refusing for the same drug and in two other cases putting intense pressure on their members to undergo this emasculation.

Now, I am not quite so familiar with the cost of hysterectomies or estrogen and other treatments, but it doesn't take you very long, Ms. Johns, to suggest that this gatekeeper in the managed-care thing looks at you and says wait a minute, \$20 a month for estrogen is \$240 a year, a couple thousand dollars for a hysterectomy. I don't know, gee, you are young, you are going to be on this drug for a long time. It will be a lot cheaper, you get the hysterectomy and not the drugs.

Now, if that decision is made on some kind of a Lotus spread sheet depending on their interpretation of how long you are going

to live, we are in real trouble, and there is story, after story, after story in this newspaper of just those kinds of decisions being made by managed-care people, and that is why we need some kinds of ideas as to how we can have a disincentive to these profitmaking operations from doing this kind of thing. And any suggestions that you have or any sets of rules that you have seen or any standards or any State regulation that makes sense to you would be appreciated, because I think it is incumbent on us to add that to the legislation if we are going to encourage the use of managed care, we have to make sure that it is a fair treatment to our constituents.

[The following was subsequently received from Susan Dooha:]

During the February 2, 1994 public hearing on health reform issues relating to managed care our testimony referred to problems with generalist gatekeepers for persons with disabilities and chronic conditions. At that time, the Chairman of the Subcommittee made a request for language that would permit persons with disabilities and chronic conditions to continue to have access to appropriate care coordination through specialists and specialty care coordination centers..

The following supplementary testimony addresses this request on behalf of New Yorkers for Accessible Health Coverage. Our response is based on concerns shared and conclusions reached by a wide range of national organizations. The Consortium of Citizens with Disabilities, a national coalition of more than 100 national organizations which serve and advocate on behalf of people with disabilities and chronic conditions, offered the following language as part of its statement before the U.S. Senate, Committee on Labor and Human Resources.

New Yorkers for Accessible Health Coverage recommends:

1. Any health plan which utilizes a gatekeeper or similar process to approve health care services prior to their provision, shall provide each enrollee who has a chronic condition or disability likely to require substantial health care services over a prolonged period of time, a choice of his or her gatekeeper physician from a panel of physicians which shall include specialists in the medical management of the condition. The National Health Board is authorized to develop guidelines to assist health plans in determining which physicians are specialists in the medical management of the conditions or disabilities defined by the Board under this section. A health plan shall annually establish panels of physicians who agree to serve as gatekeeper physicians, including specialists in the medical management of chronic conditions or disabilities.
2. Any health plan must have sufficient contracts with eligible academic health centers and centers of excellence so that their enrollees can receive specialized treatment services. There should be incentives for plans to contract with as many providers as necessary to meet the health care needs of their beneficiaries, particularly persons with disabilities and chronic, disabling illnesses.
3. There should be effective quality assurance mechanisms in managed care plans to ensure that people with disabilities and chronic conditions who need ongoing specialized services have appropriate access to these services, and should not be financially penalized when their medical condition requires specialty services.
4. Cost-sharing provisions must include subsidies for all low income persons with disabilities and chronic illnesses to join the plan that is best able to meet their needs.
5. Physician referrals to specialists must be financially neutral and based solely on the health needs of the patient. Just as physicians should not receive payment for referrals, so they should not receive payment for denying referrals. The legislation must expressly prohibit financial penalties for making referrals and bonus payments for not making referrals.
6. There must be a prohibition against balance billing for medically necessary services obtained outside a network.

Mrs. Johnson, why don't you have at the panel.

Mrs. JOHNSON. Thank you, Mr. Chairman. I appreciate the panel's excellent testimony. Maybe you will be surprised to know I don't disagree with any of it.

What enrages me about GAO is that the studies they do don't help us to really get at reality, and at the end it is all inconclusive.

Miss Dooha, your comments were absolutely on point, and I appreciate your specific recommendations, and it is very interesting that our Nation has far better experience in coordination with severe and unique situations, and what managed care is really all about at its simplest level is trying to figure out how to do that for the ordinary guy.

I mean, we have tons of information showing the high percentage of admissions among seniors that are due to overmedication and the interaction of prescription drugs, and we have had that for a decade, but we have not adopted in Medicare any serious approach to medication management or managing that part of the medical record of a senior, so I mean we really know management helps.

It has to be enlightened management. It can't be management that doesn't let you go to those services that you need, but if in the long run the reorganization that I think both the administration and most of us are interested in does provide integrated systems of the care as opposed to managed care, you should be able to get the very management that you are talking about and the appropriate services with the cost savings being the elimination of overhead administrative costs, but also inappropriate utilization.

And if we are going to add all the things that we are all interested in adding, we have to be equally serious about savings. I mean, this Government has never reimbursed for prescription drugs, not even estrogen for women over 65, when we know fragility of bones is the primary cause of women being in convalescent homes, so there is no record in the public sector of enlightened reimbursements.

I mean, we don't provide contraceptives. That is ludicrous. So I think as we think about what we need to do better, certainly coordination has got to be very, very high on our list, and I do appreciate your specific recommendations.

I would remind you that the administration also eliminates the drug treatment block grant that is the only money in my State available to provide long-term coordinated care for people damaged by drug use, and if we lose that money, we will end up having them in \$10,000 detox cycles 4 or 5 times a year, costing money, for a terribly diminished level of care, and yet the administration's plan would not enable us to take care of them, and with the health block grant we won't have any way, so there is no perfect bill on the table right now, and your kind of testimony has really made that clear.

Ms. Johns, I really appreciate, I have to admit I have an interest here. My husband is an obstetrician and gynecologist. However, he is about to retire, so this will not affect him one way or the other, but one reason that obstetricians and gynecologists were counted as primary care was because the women in Congress got very involved in that issue and lobbied hard.

Now, the good news is we won. The bad news is America's people can't be dependent on Congress like that, so at the same time I appreciate the problem that you have in northern California, I do think the consumer information provisions that were pointed to earlier in this hearing and that now all plans on the table include are going to give us a far more powerful way to address these issues far earlier in the process so that we can create a far more responsive system.

I would just remind you that while it may be a benefit to have the national plan identify ob/gyns as primary care physicians, it is a real disadvantage to have the national law say how often women can have mammograms, because when the science says it should be a different frequency, we will not be able to get the bill on the Floor because our benefit changes will have costs, the other guy's benefit changes will have costs and so on and so forth.

Pretty soon it will do what you see over and over again in Congress, good legislation dying because it has grown, it is costly, and we can't pass it, so I really worry, and I think you should be thinking with me more about what are the options to a nationally specified benefit plan.

That is a bigger issue, but it is a very serious one. It is increasingly serious. When it really got to me was when I saw the President's plan specifying how often I could have mammograms, at what age, and have it included.

Mr. Campbell, I listened with interest to your concerns and share many of them. I am surprised that none of you mentioned the role of the community health centers in all of this and how imperative it is that we allow them to develop, as they are currently trying to develop into managed-care systems. Far more user friendly, there is no need for insurance companies to be involved in every managed-care system. There is certainly no reason why a group of doctors in a local hospital can't develop a system that is much more user friendly to their neighborhood, to their town.

I am encouraging my small hospitals in towns to do this, and we want a Federal law that is flexible enough for that. The President's law is not flexible enough for that because to be an accountable health plan you are going to have to be able to serve the whole area that has been designated by the alliance, and the politics of designating those areas are going to mean that they are going to have to be larger than the area that many of the rural community hospitals serve, and the surrounding towns, they can serve themselves. They can't go outside and the State designation areas are going to compromise availability of service simply through bigness.

Certainly, it won't have the responsiveness of local hospitals, so that is a bigger issue. I hope you will use your roots in the real world out there at the community level to help us work through those issues because the way the accountable health plan, global budget, premium-setting structure is set now, States will have practically no choice, and small States, an accountable health plan must be able to serve the whole State, for instance, of Connecticut.

And if they have to do that, then Torrington Hospital with the towns around it and its doctors can't be an accountable health plan because they can't serve the rest of the State, so I just point out

to you some of the problems that are between the concerns that you have and radical national action.

And I guess, Dr. Rowland, I would say the same thing in regard to your comments which I thought were very good. I would remind you that the Medicaid managed-care plans that are newest and are showing enormous savings and improved quality are also care co-ordination plans, and they are the first ones that have been focused in Alabama and South Carolina on specific issues like pregnancy and premature birth babies and low birth weight babies, and those kinds of things.

They have had enormously good success. I hope we can be able to bring care out of the emergency room because usually that represents care too late in the illness process, but how we do that is of enormous concern, and I think the big message that you bring us today, at least the message I get from you is the pace of change matters.

You move in a short period of time to force us all into one rigid model, and you are really going to compromise access, and I absolutely agree with you that we need to encourage change. We need to make sure it happens. We need to make sure it gets universal, but that we have to be very careful about forcing people into too rigid systems.

I thought the GAO information that showed how many people want also the flexibility to be outside the network is something we ought to remember when we set up Medicaid plans for the Medicaid population. There has to be a level of flexibility so that you get the unusual family with the chronic child to the care that they need, so I really appreciate your testimony, and will use it because the kinds of problems you point to are what reminds me that it is very important to do what we know we can do—reorganize purchasing; the way we know it is not working, but don't force everybody into a Statewide health alliance.

Just one last comment, because I would hope that you would help think this through, too, because this represents in the President's plan at least the most serious challenge to the chronic care problem, and that mechanism is spelled out in the law that forces the global budget to decline so steeply over 5 years. When that happens, then you are going to get irrational, rigid forcing of people into certain care systems, and it is going to be very harsh—the first thing to go are going to be the expensive care settings, and I don't—I think experience documents that.

I don't think we can go from the highest medical cost inflation to the lowest in the world in 5 years without forcing straightjacket solutions on to communities and particularly low-income cities. No way we can survive that. I hope you will work with us for a more flexible solution to our health care problems, but one that does end up in the goal that people like myself and the President share, which is universal care for all Americans.

I thank you for your testimony. Appreciate that, Mr. Chairman.

Chairman STARK. Thank you. I have one just final request of Dr. Rowland. All through the President's plan he either states or it is assumed that we are somehow going to take and—I don't like this word mainstream the Medicaid population into private health insurance.

He says he will do it through alliances, but however it is done, given the limits on the subsidies that are for low-income populations, do you really anticipate that the structure the President has in mind of putting the Medicaid beneficiaries into the lowest cost plan in town that they are going to end up with what you and I would call—I trust by mainstreaming he means what the average person in the community has in the way of health benefits. Do you think that is going to happen?

Ms. ROWLAND. I think given the structure of the cost-sharing plans that are offered under the President's bill, the choice for low-income people will be limited only to those plans that have very low cost-sharing because the fee-for-service option, with its higher cost sharing, is not going to be subsidized for any of the patients. And the AFDC and SSI populations will have cost-sharing subsidies only if they chose an HMO. So I think the cost-sharing structure naturally is going to limit the options for the Medicaid population or the low-income population to the HMO-type entity and really preclude a fee-for-service choice.

But also I think it is going to be very difficult in some inner-city areas with large concentrations of low-income populations to find plans that have a broad enough payer mix to subsidize the costs of the low-income patients in the plan. These low-income populations have more complex health needs and providers may not be adequately reimbursed in comparison to with privately-insured patients that have a higher reimbursement rate. Therefore, you may find a concentration of the poor into several low cost plans that may, in fact, have financial difficulties being able to operate.

Chairman STARK. OK.

Ms. ROWLAND. So I think that really warrants a great deal more attention.

Chairman STARK. Mr. Campbell, did you want to comment?

Mr. CAMPBELL. Chairman Stark, my understanding of the President's plan was that it was to put folks into the average cost rather than the lowest cost plan, and, frankly, one of the things that my clients are excited about is the ability to get into an average cost plan and the possibility of mainstreaming.

With all due respect for the good work that is done at the community health centers, some of my clients would like to know that they can go to other places, as well, if they had the opportunity.

Chairman STARK. Well, where are your clients located?

Mr. CAMPBELL. Throughout Pennsylvania. That includes rural areas. Our office is in Philadelphia, but we have folks throughout the State.

Chairman STARK. We have some unusual pockets, not one very close to where we are now, where there aren't going to be any plans. I mean, Prudential has already testified that they won't open up their provider network to Medicaid beneficiaries, and there aren't many plans down there now. There are 150,000 people in the District of Columbia who need it. We have about 12,000 of them in plans, and in their neighborhood they will be in the average plan, but you service 150,000 people with half a dozen primary care providers, four of whom are pediatricians, and you are skating pretty thin. I am guilty of often suggesting that rural folks only

have to drive 20 miles. It doesn't seem so far to somebody who commutes on the freeway.

But on the other hand, from Wards 7 and 8 in the District of Columbia, the trip by bus to the fancy medical centers at George Washington University is two transfers, and in this kind of weather if you have to get two kids on the bus, one of whom is sick or the mother on the bus, you are talking about 2 hours, and 2 hours on the bus is something that might make you sick if you weren't sick when you started. It is a tough journey. It is hard to recognize that, but that is generally just what will happen.

Those are the concerns I have, that just by happenstance we will still impact on those less fortunate populations, and they, just by the luck of geography, or the absence of the quality providers, won't get much care, and by those standards, those community clinics look pretty good. You can lead a horse to water, but you can't make it drink. I don't know how you write into legislation making these profit-oriented groups provide social service.

There is a conflict there. You are either in business to make a profit or you are operating an operation for an eleemosynary and social purpose. I have never been one to feel that you can force profitmaking operations to do charity care. That just doesn't make sense.

Mrs. JOHNSON. Mr. Chairman, could I comment on this particular point?

Chairman STARK. Sure.

Mrs. JOHNSON. It is because of that problem that you raise that you end up with Statewide accountable health plans. If you have an accountable health plan and it serves Washington, D.C., it is going to be very costly because it has got to pay the costs of all of the poor people in Washington, D.C., and then Washington, D.C. would have a higher premium under the President's plan than the suburban areas adjacent to it, and so when businesses look at where they are going to settle, you have one more disincentive for jobs not to be created in the city, so when you look at how you are going to share the costs under the President's plan, you end up having a lot of trouble defining the borders of the areas that the accountable health plan has to serve.

And in order to get away from that border problem where premiums will change, particularly in small States or in a State with one large urban area and a lot of rural areas, you are going to end up with Statewide alliances, and the only companies that can afford to be an accountable health plan are companies with the capital to set up a Statewide alliance.

So the logic that forces bigness in the President's plan is inescapable and a problem. I want a more flexible solution than that, and I think it is perfectly doable, so that is going to be the stuff of next month's debate, but I do think that you ought to be conscious of how the President's proposal does encourage the accountable health plans to be macro plans and the impact that that is going to have in terms of rigidity, choice and responsiveness. Thank you.

Chairman STARK. Thank the panel very much. You have been very helpful. I appreciate your patience, appreciate your coming here today.

Our next panel will discuss managed care from the perspective of providers, and the witnesses are Dr. Robert Montgomery, representing the American Group Practice Association; Dr. James Reinersten, the vice president and chief quality officer of that organization; and G. Aubrey Serfling, who is president and chief executive officer of the California Pacific Medical Center.

Welcome to the committee, gentlemen. Dr. Montgomery, why don't you lead off.

STATEMENT OF ROBERT C. MONTGOMERY, M.D., PRESIDENT, AMERICAN GROUP PRACTICE ASSOCIATION, AND MEDICAL DIRECTOR, MERITCARE MEDICAL GROUP, FARGO, N. DAK.

Dr. MONTGOMERY. Thank you, Mr. Chairman and Representative Johnson. Good afternoon. I am Dr. Robert Montgomery, medical director of MeritCare Medical Group in Fargo, North Dakota, and president of the American Group Practice Association. I want to thank you for affording the American Group Practice Association this opportunity to testify today.

Group practices are optimistic about their role in a reformed health care system, but they fear some of their innovations may be stifled. We urge Congress to look carefully at the mission, structure and accomplishments of group practices and the integrated delivery systems that they have developed.

In our written testimony, we elaborated upon the elements which distinguished group practice from other forms of practice and which enable them to provide quality, cost-efficient care. With or without Federal legislation, reforms are sweeping the States and medical marketplace.

Market reforms were initially driven by business community determination to hold down costs without compromising the quality of care for their employees. Group practices have accepted the obligation to reduce costs and demonstrate verifiable improvements in the functional outcomes of the patients who utilize their services. Group practice initiatives are compelling other providers to meet the same high standards.

Payers, especially those businesses that have combined to create purchasing coalitions, are increasing their demands for efficient use of health care dollars because of the effect of health care costs on their competitiveness. They want to buy care based on documented outcomes. They want consistent quality and processes. They don't want a health plan deal. They want a real partnership with their providers.

In short, they want value. Managing care and managing money are not the same. Physician-led group practices have found that the best way to deliver cost-effective, high quality care is to manage patient care instead of managing the premium dollar. A group practice culture is based on teamwork and an interdisciplinary approach to patient care that focuses on improving what is most important to the patients—health and well-being.

The best measure of the success or failure of these providers is the quality of the clinical outcomes of the practice. I have evidence from group practices of the success that is achieved through the proper managing of patient care.

Mayo Clinic's growth in spending per capita did not exceed GDP growth from 1988 to 1992. At Henry Ford Health Systems HMO rates have grown at an average rate of 7.15 percent between 1985 and 1993. There is evidence from various markets around the country that the transition from fee-for-service dominated markets to capitation dominated markets can occur quickly and with dramatic cost containment results.

For example, in Los Angeles the top seven accountable health plans provide comparable care for annual premium amounts that range from \$1,200 per person per year to \$1,400. The premiums for similar plans in less competitive markets range from \$1,500 per year to \$3,500 and more per year. The savings that could result from competition in these localities could exceed \$200 million per 100,000 people.

Group practices support many of the reform measures contemplated in the President's plan that would lead to heightened system efficiency and quality improvement. While delivery system reform is necessary, we do not believe that you can succeed if these changes are brought about too rapidly. Market reforms on their own have significantly changed the way health care is provided in many communities.

We recommend that you carefully deliberate the changes you expect and monitor their progress to assure that the changes you want are what you get. Thank you.

[The prepared statement follows:]

**TESTIMONY OF ROBERT C. MONTGOMERY, M.D.
AMERICAN GROUP PRACTICE ASSOCIATION**

Mr. Chairman and distinguished members of the Ways and Means Committee, I want to thank you for affording the American Group Practice Association this opportunity to testify today. As this Committee and Congress consider the President's health reform bill and the other reform proposals, the challenge will be to balance carefully the powers of the health alliances, the mechanisms of cost control, and potential barriers to the integration of health services with the need to support and encourage effective delivery systems already emerging in the marketplace.

AGPA shares the desire of Congress and the President to reform the nation's health care system. We commend the President for his focus on universal coverage, quality care and cost containment. Group practices are optimistic about their role in a reformed health care system, but they fear that some of their potential for innovations may be stifled. We urge Congress to look carefully at the mission, organizational structure and accomplishments of group practices and integrated delivery systems. Please recognize these systems have not been created overnight. Successful integrated group practices are the result of planning and attention to mission, vision, and culture. Legislation that would compel their creation, as well as a dramatic restructuring of the rest of the market will certainly lead to massive business failures by new entrants to the market which fail to appreciate the sophisticated governance mechanisms required to manage such groups.

The elements that distinguish group practice from other forms of practice and which enable them to provide quality cost efficient care include their ability to:

- * function as one organization with a common mission and governance;
- * compete on the basis of quality and outcomes;
- * utilize a common medical record;
- * manage episodes of care, rather than isolated medical incidents;
- * utilize interdisciplinary patient care management teams;
- * utilize on-line information systems and communication networks;
- * manage costs and utilization among patients and providers;
- * utilize Continuous Quality Improvement to instill long-term improvements;
- * maximize utilization of primary care physicians and nonphysician practitioners;
- * select physicians on the basis of quality and cultural compatibility;
- * match services provided with community/client need;
- * serve large populations;
- * share liability, responsibility, and professional reputation;
- * allocate resources to research, education, and technology; and
- * establish economic interdependency among providers in the group.

With or without federal legislation, reforms are sweeping the states and the medical marketplace. Market reforms were initially driven by business community determination to hold costs down without compromising the quality of care for their employees. Group practices and other integrated delivery systems have accepted the obligation to reduce costs and demonstrate verifiable improvements in the functional outcomes of the patients who utilize their services. Group practice initiatives are compelling other providers to meet the same high standards.

Group practices are responsive to the demands of their local market. Payers recognize one way to get value is to pay one organization for "full-service" care --primary, acute, rehabilitative and nursing care -- that their employees' or enrollees need. A growing trend is for employers to directly contract with group practices for their employees health care, working in a collaborative manner to deliver effective and high quality patient care.

Payers, especially those businesses that have combined to create purchasing coalitions are increasing their demands for efficient use of health care dollars because of the harsh effect of health care costs on their competitiveness. They want to buy care based on documented outcomes. They want consistent quality and processes across the system, and they don't want a health plan deal -- they want a real partnership with their providers. In short, they want VALUE. In Michigan, General Motors asked Henry Ford Hospital in Detroit to provide health services at no increase in cost for the next three years. In California, Calpers asked providers to reduce charges by 5% in 1994. And in Minnesota, a coalition of businesses in the Twin Cities is driving providers to provide quality at lower costs.

It is our conviction that group practice leaders of the future will be change agents, directing facilities that deliver cost-efficient, high-quality care focused on maintaining health and preventing sickness for large populations. Physician led -- and I emphasize physician led -- group practices are already leading a transformation in the marketplace.

Managing care and managing money are not the same thing. What we are seeing in the market is a shift in the managed care paradigm. It is a shift from the insurance company mode of managing dollars to physicians maximizing the health of the citizens in their community.

Group practices have found that the best way to deliver cost effective, high quality care is to manage patient care instead of managing the premium dollar. This requires the development of a corporate and practice culture that is motivated to maintain the health of the community. A group practice culture is based upon teamwork -- an interdisciplinary approach to patient care that focuses on improving the functional status, quality of life and the health of patients. The best measure of the success or failure of these providers is the quality of the clinical outcomes of the practice.

The group practice setting is ideal for large scale outcomes measurement and the application of continuous quality improvement because care tends to be delivered in a comprehensive manner to large and stable populations. Many AGPA members are involved in outcomes measurement and are using their findings to define best practices. The development of on-line databases for tracking clinical effectiveness and outcome studies have enabled group practices to utilize resources to improve quality and outcomes in the targeted group, enhance access by eliminating unnecessary procedures, and cut costs by eliminating procedures unlikely to benefit anyone. Continuous improvement methods strip out the steps in daily practices which do not add value, and help group practices improve the quality of what they do at a lower cost.

Currently, more than 30% of all physicians practice in groups. Modern group practices operate in rural, urban and suburban locations and have satellite clinics that serve large geographic areas and population groups, including locations categorized as under-served. We believe that in the future most practicing physicians will belong to group practices and integrated delivery systems and that they will be working for a salary, contracting with the organization to deliver services on a fee-for-service basis or receiving a capitated payment for their services.

The growing trend is for smaller groups to unify into a larger multispecialty group, and for a group to integrate with other health care entities such as hospitals or insurers, with the goal of creating a delivery system that can offer a seamless flow of services, including acute care and tertiary care and in some cases, long-term care and home care.

In the current markets that are dominated by fee-for-service systems, groups provide care more efficiently and effectively than non-affiliated providers because they eliminate redundancies in care.

Because their services are comprehensive, they are also capable of delivering a complete range of services for a fixed, capitated payment. Many participate in managed care programs under capitated payment structures which shift the financial risk of health care delivery to the physician group. Patient care delivered by an interdisciplinary team offers many advantages over less structured fee-for-service care. Within this framework, physicians can direct resources more appropriately, streamline paperwork, and focus on population-based health outcome improvement. Because groups are able to manage the complete care of a patient, they are able to avoid the incentives for inefficiency that exist in the fee-for-service system. For this reason, these systems of care are strategically positioned to adapt to the changes called for under reforms contemplated by the President and the transitions expected in the years to come.

Group practices support many of the reform measures contemplated in the President's plan that would lead to heightened system efficiency and quality improvement. While delivery system reform is necessary, we do not believe that you can succeed if these changes are brought about rapidly. In fact, you have recently heard testimony from the noted economist and Physician Payment Review Commissioner Uwe Reinhardt that many of the reforms proposed as managed competition would lead to the collapse of the fee-for-service system. Market reforms on their own have significantly changed the way health care is provided in many communities. We recommend that you carefully deliberate the changes you expect and monitor their progress to assure that the changes you want are what you get.

HEALTH REFORM

A desire for high quality care, coupled with the absence of incentives to contain costs, has produced vast technological breakthroughs, but has also resulted in a level of cost escalation that is unsustainable. This has been aggravated by a climate in which the public expects immediate access to the latest technology and therapy, and then anticipates near perfect outcomes no matter how perilous the clinical situation. The growth in

health care expenditures has contributed to vast numbers of young, unemployed, and underemployed people not participating in our health system.

AGPA believes that Congress must establish a sound public/private sector health care system. Providers, insurers, and purchasers need to move from providing care on a case-by-case basis to physician-directed health plans and integrated delivery systems. The current health care crisis is as much a problem of fragmented health care delivery as it is a problem of insurance coverage. To foster the development of integrated delivery systems, barriers to integration must be eliminated. Additionally, before the United States can create a national system with universal access, the disincentives to appropriate care in the current system must be corrected.

Arnold Relman, M.D. recently stated: "No new system can succeed unless it encourages doctors to function as trustworthy advocates for their patients, uninfluenced by the economic interests of the owners of the plans while still responsive to legitimate cost concerns." The group practice model is an organizational structure that fosters the development of patient centered health plans.

Based on the experiences of many of our members, AGPA can cite some of the essential elements of a physician-led health plan:

- A health plan must be able to manage total costs, rather than maximize the revenues and profits of each part of the system.

To accomplish this a health plan must encourage give and take among the departments and organizations in the system. Resources must be rationally planned, which drives right sizing and reconfiguration of physicians and technologies. Productivity must be redefined from dollars booked per physician to total population which receives excellent care per physician, regardless of dollars booked. Incentives also must be restructured from fee for service to salary, and from bonuses for unit profitability to system-wide sharing of success. Finally, the aim of the health plan must change from "all the care that's in the best interest of our patients," to "all and only the care that's in the best interest of our community of patients."

- Focus on a population, not just on individual patients.

To accomplish this the health plan must ask "Why does this community have a health system?" The health plan must face tough resource allocation questions, such as non-ionic contrast versus mammography. Delivery processes must change radically from a ratio of one physician per patient (1:1) in offices to 1:100's in communities. Lastly, the health plan must work to change the public mindset about health care to address the tension between "Health care costs too much and doctors should do something about it," and "Don't skimp on me!"

● **Become customer-centered, process focused, data driven and innovative.**

This will require health plans to learn and apply continuous improvement theory and methods, not to just pay lip service to CQI as a marketing tool. Health plans must also become process and system literate, rather than loosely organized as a series of department and revenue centers. Measurement and data skills in daily work are also essential, and should not just be the job of the statistics and research personnel. Organizations become what they measure.

Health plans should be held publicly responsible for the costs and effectiveness of their medical services and for levels of patient satisfaction. Health plans should be required to provide an array of "uniform effective health benefits." AGPA believes that by law, the standardized benefit package should have a co-payment for all services except specified preventive services. The personal out-of-pocket payments should be subject to an annual maximum amount. Financial incentives to improve lifestyle should be incorporated into the benefit package and its pricing.

The services included in the basic health benefit package should be chosen based on scientific evidence of treatment effectiveness, societal values regarding appropriateness, and on an analyses of relative costs and net benefits. Current research being conducted by the Agency for Health Care Policy and Research, and organizations such as AGPA, will facilitate the design of an appropriate benefit package.

Health Reform Issues for Group Practices and Integrated Delivery Systems

AGPA has closely reviewed President Clinton's "Health Security Act", the "Managed Competition Act" and the single payor options. AGPA has targeted several issues in these proposals which are key to high quality patient care and to the success of group practices and integrated delivery systems:

- *Quality: Accountability in Medicine*
- *Role of Health Alliances*
- *Fostering Innovation and Competition*
- *Graduate Medical Education*

Quality: Accountability in Medicine

AGPA began its outcomes measurement effort in 1989 by studying the feasibility of collecting and using a standard set of outcomes information across diverse medical groups. It was the expectation of the first six participating clinics that data collected from patients and clinicians during the health care experience could yield significant new insights into the impact on patients' functioning and well-being. Early results made it clear that outcomes measurement can be used to redesign patient care systems to produce desirable and replicable results.

Today, AGPA's effort includes 50 medical groups and seven health conditions: total hip replacement, total knee replacement, cataract surgery, diabetes, adult asthma, low back pain, and hypertension. Along with its distinguished member medical groups, AGPA has gone beyond testing the feasibility of a patient-centered outcomes approach to designing models for integrating outcomes information with practice improvement.

Medical groups recognize that they have the tools needed to revolutionize the delivery of medical care. It is possible to control the cost of health care only if providers know which interventions produce effective clinical outcomes at what cost. We must be able to understand the value of the health care we are delivering. Information on the outcomes of care (functional status, well-being, clinical outcomes, satisfaction, and cost) will make possible the difficult task of lowering costs while preserving quality. Medical groups that have a scientific basis for managing care will have a competitive advantage.

Another reason behind the enthusiasm for outcomes measurement is the distinct difference between measuring the results of care and tracking the performance of a particular physician or health care system. It is important to know such information as how many immunizations, mammograms and flu shots are delivered to a certain population and to know whether patients have access to the physician they want to see in a timely manner. All of the efforts, such as HEDIS, NCQA accreditation, and report cards, will give consumers and purchasers information with which to make educated decisions about where to purchase health care.

However, these efforts will not assure quality care for all Americans at a reasonable cost. Taken out of context, or left to stand on their own, these "performance indicators" may perpetuate inefficiency and waste. Without ongoing outcomes measurement we may find ourselves with a health system that provides a set of minimum benefits to all Americans and never know the effectiveness of the services delivered. Outcomes measurement that drives continuous improvement assures that providers are "doing the right things right."

The AGPA urges Congress to take steps to further develop clinical information systems to improve medical decision-making, compel insurer and provider organizations to be accountable and effective, and to develop a competitive market structure that rewards insurers and providers for balancing medical care costs, quality, and patient satisfaction. AGPA supports additional funding for research in the outcomes sciences.

The essence of this work is to achieve high quality outcomes while using fewer services per patient episode. The organizational structure of a group practice creates a framework for promoting simultaneous improvements in quality and efficiency. The group practice structure provides a vantage point which permits physicians to see the impact of resource allocation on the health of the whole population of patients under the groups' care. This population orientation leads group practices to emphasize cost-effectiveness and efficiency issues in order to identify practices that represent a good value to the population.

The search for high value practices has lead group practices to participate in the collection, pooling and use of objective data regarding the impact of medical treatments

on the function and well-being of patients. Such information can be used to promote informed decision-making by patients and physicians. The information can also be used to compare outcomes of different institutions and physicians using different treatment approaches for similar patients in an effort to identify optimal practices as well as discover opportunities for improvement.

Role of Health Alliances

Health alliances and purchasing cooperatives are organizations that would act on behalf of purchasers to rate and offer certified health plans. Reform proposals differ as to whether the alliances would compete, be voluntary or mandatory, who they would be open to, the nature of their buying responsibilities, and the kind of certified health plans they offer. The policy objective in their creation is to facilitate pooled purchasing, minimize administrative overhead, maximize choice of health plans to purchasers, and provide evaluative information on the quality of plans to buyers.

The authority delegated to alliances in the President's plan will interfere with successful group practice strategies to reduce costs and demonstrate verifiable improvements in the functional outcomes of the patients who utilize their services. Group practices are confident that they will prosper in the basic health plan/health alliance structure, but would prefer for alliances to operate more simply as buying cooperatives with limited regulatory powers. Some of our concerns with the health alliances are:

Quality assurance: AGPA is concerned that the health alliances and the National Health Board may preempt or stifle the work already underway by many group practices on outcomes measurement. It is vital that quality control be physician driven with a focus on improving functional outcomes. The government's role should be limited to taking steps which promote the establishment of a competitive market based on good information about costs and quality. Direct governmental involvement conducting surveys, preparing reports, and developing practice standards constitutes micromanagement, which may interfere with effective clinical practices.

Border issues: Group practices need the option to participate in more than one plan and in more than one alliance, especially across state lines. We are concerned about the structure of health alliances in border communities, especially with regard to the implementation of budgets. AGPA is not confident at this time that there is sufficient data to measure health care expenditures in regional health alliances accurately. There must be assurances that neither health alliances or plans will restrict access to health care services across state boundaries, and that the plans will be able to function effectively in as many health alliances as they choose.

Point of Service (POS) Requirements: AGPA is concerned about the development of a point-of-service requirement for health plans. For many group practices, especially those that are high level tertiary care centers, it is crucial that patients have the freedom to go out of network. However, for other groups, especially

those that are capitated, the requirement that health plans must offer a POS option may create problems in controlling costs and quality. In addition, under current tax law, nonprofit group and staff model HMOs can keep their tax-exempt status only if out of network use of services is "insignificant." Today, the market is driving more health plans to offer POS options, and where it is determined to be manageable, health plans are offering such a product. Setting up POS options requires investment of time and capital. They must be carefully crafted to respond to the needs of local markets and of local providers. For such an option to work, health plans must be able to utilize mechanisms such as coinsurance and deductibles to manage the extra costs that may be incurred by patients going out of network. To control quality and costs, some health plans currently require plan members to use in-network providers for prescription drugs, well-baby care and prenatal care. We therefore recommend that a POS option be voluntary and not a mandatory provision.

Risk Adjustment:

The ability of health alliances to make accurate and timely risk adjustments in premium payments to health plans is crucial to the viability of cost effective, high quality providers. The accuracy of risk adjustment takes on more significance in the context of global budgets because of the squeeze on resources that could take place for those providers who care for high risk populations. The Clinton plan calls for the National Health Board to develop a mechanism that takes into account the demographic characteristics, health status, geographic residence, socioeconomic status and the proportion of cash-assistance recipients enrolled by a plan. Unfortunately, no current model of risk adjustment exists that takes into account all the risk factors of a regional patient population.

It is a risky venture to have an element of a comprehensive health reform plan depend on a mechanism that does not currently exist. If risk adjustments are not implemented correctly there are cushions, such as the health alliance borrowing money or the president requesting a change in the budget level. However, it is not comforting that providers in high risk areas must rely on supplemental appropriations to cover the full costs of care for patients, or for citizens in high risk areas to be required to repay loans given to the health alliance. These provisions have serious implications for the cost containment goals that are such an important part of the president's plan. Serious consideration should be given to reinsurance mechanisms to protect providers and consumers until we are confident that adequate risk adjustment mechanisms are in place.

Graduate Medical Education

The functional requirements of health plans will lead to decreased requirements for specialty physicians, and perhaps even decreased requirements for primary physicians. Health reform will also cause us to focus more on the numbers of "other care providers" that are utilized.

AGPA commends the President for the recognition he gives to medical education in his health plan. His plan preserves a strong role for academic health centers and begins the development of a national system for directing medical education. We support the emphasis on primary care, but are not comfortable with some of the prescriptive elements of the bill. AGPA believes that the market place should drive the supply and demand of physicians and that freedom of choice for those pursuing medical training should be preserved.

Medical education reform proposals fail to adequately engage the health care delivery system in workforce planning and training. Fundamental changes in the reform proposals will be required to reach the goals of increasing the supply of primary care providers, and improving the ratio of generalists to specialist physicians graduating from U.S. medical education programs.

We recommend a strong role for integrated health systems in the training of practicing physicians in the principles of managed care, as well as for training physicians in the principles of Continuous Quality Improvement utilizing practice guidelines, outcomes measurement and other improvements. Integrated health systems will also be important structures in retraining physicians for needed medical services.

The deficiencies of the existing academic program model for effective workforce planning are particularly evident when planning for future workforce needs including nurses and other primary care providers (as is envisioned under the Clinton bill). Primary care needs under health reform and demands for cost effectiveness mean that some of the primary care needs will be filled by people who are not trained as physicians but who can do the job within the context of an integrated health system as part of a team led by physicians.

An effective training program model would place purchasers and the integrated health systems (as customers) in a position to project comprehensive workforce needs and help manage supply. The new model should allow integrated health systems that provide training to apply to the federal board for training slots that not only fulfill their physician and other provider training missions, but also bear a relationship to their own projected workforce needs.

A new program model should permit integrated systems that do training to have independent standing with the universities regarding allocation of training slots and funding. Funding should be made available for training in ambulatory settings.

From our own experiences the marketplace is already working. Integrated systems which are focused on providing care to given populations have already begun to restructure their medical staffs at the lowest specialty to primary care ratios practicable. As health systems became cost centers, instead of revenue centers, the market for excess specialty services dried up. Health System Minnesota is currently at 50% primary care providers and is no longer recruiting specialists. Another large system with 2500 specialists under contract has reduced its specialists to 1500 and they will further reduce this to 1000 by

1995. At this level they will have 50% primary care physicians, and 50% specialists.

Many AGPA member group practices have as a part of their structure both hospital and clinic services. What these groups have to offer are unique training settings where a resident can experience learning in both ambulatory and hospital settings. We would suggest that much of the debate concerning graduate medical training has been too limited to the consideration of medical schools and hospitals. We consider it vital to point out to the Committee that currently many group practices which do not have their own graduate medical education programs are involved in the GME program of an affiliated hospital, and often provide the training in the ambulatory setting for those residencies.

Other well known group practices offer GME programs which are not affiliated with a university program. We urge Congress to recognize the important role played by non-university GME programs located in group practices. Techniques should not be adopted for allocating resources that might bypass these centers of excellence in an attempt to optimize outputs. AGPA also supports the need to increase the emphasis on training in ambulatory care settings.

For medical education reform to be successful, group practices believe the following basic principles need to be followed:

Flexibility: The federal government should retain flexibility to build upon the existing training network with all its variations, so long as these local entities are able to contribute to the national health care workforce objectives.

National goals: While attention must be paid to areas of significant undersupply, such as remote rural areas and inner cities and should be addressed in part through the training process, the overall perspective must be national.

Program mix: The nation will continue to need centers of excellence to for care patients with complex illness. Therefore, we support an approach that continues to allow for institutional variation within a system that achieves a better training balance between generalists and specialists.

Individual incentives and choice: We support approaches that respect individual trainees decision-making concerning one's career. We also support the necessary reforms to address both supply and mix. We believe this can best be achieved by attention to explicit incentives that encourage individuals to make decisions consistent with overall system needs. Compensation, which is an important part of this equation, is but one aspect. Assistance must be provided to both individuals and organizations to make the care setting more satisfying and to provide the social and professional support needed to ensure quality patient care.

Financing: We support the concept that all payers, private and public, should contribute a fixed percentage of premium cost or capitation rate for the training of our future health care professionals. In terms of the added costs to providers

caused by the presence of trainees in the delivery setting, we support a formula-based additional payment to providers for these additional costs to encourage providers to continue to be a key part of the training system.

Cost Containment

AGPA prefers to rely on a market-based system for cost containment, wherein all the participants can respond to market incentives to continuously improve standards of care in a cost-effective manner. Group practices do not support a federal all-payer rate setting system or global budgets. Philosophically we view such proposals as inconsistent with the concept of managing patient care, especially if such a budgetary cap leads to wage and price controls. Strict budget controls implemented and enforced away from the clinical setting could severely distort incentives and possibly weaken the quality of care delivered.

We must focus on the goals of cost containment, access and quality simultaneously -- a balancing act that brings into play several dynamic forces. On a smaller scale, group practices, employers and managed care organizations have been trying to conduct this balancing act and in some cases have produced favorable results. They have created innovative delivery systems utilizing available resources and responding to local market forces.

A system with government enforced budget constraints means the government must have an accurate measure of the resources that are necessary to accomplish the goal of universal access and quality from both a national and a local perspective. For example, sufficient resources must be available for achieving technological advancements, creating new infrastructure and managing traumatic medical events. If resources do not meet the demands placed on providers, the country will fall short of the president's goal of universal coverage, and quality of care may be sacrificed. Cost containment is an absolute, but it must be a dynamic process that takes into consideration all the forces of health care delivery.

Managed care has been successful in achieving cost containment in isolated circumstances but has yet to cause significant cost savings on a national scale. A major reason for this is that market competition has not been truly allowed to work. The practices of purchasers, the tax laws, and other market imperfections have led to "cost-unconscious" demand. The result is that the demand for managed care becomes price-inelastic. To make purchasers more cost-conscious, employer and government sponsors must convert to defined-contribution health benefit programs; tax-free employer contributions must be limited; benefit coverage within sponsored groups must be standardized; and premiums must be risk-adjusted.

We have evidence from group practices of the success that is achieved through the proper managing of patient care. Mayo Clinic's growth in spending per capita did not exceed GDP growth from 1988-92. At Henry Ford Health System's HMO, the capitation which physicians in the Henry Ford Medical Group receive, to cover all professional

services, inpatient care, ambulatory care and covered ancillary services has grown at an average rate of 7.15% between 1985 and 1993. This compares to an 9.95% annual growth rate in per capita national expenditures for comparable services. Henry Ford also has evidence that once efficient practice patterns are developed, there are verifiable carry-over cost benefits to fee-for-service populations served by the same physicians. For example, for services provided to the Medicare patient population, the annual increase in the average Medicare payment to Henry Ford Medical Group averages 4.5% since 1988, compared to a national average of 7.9% annual growth in Medicare costs.

There is evidence from various markets around the country that the transition from fee for service dominated markets to capitation dominated markets can occur quickly and with dramatic cost containment results. For example, in Los Angeles the top seven accountable health plans provide comparable care for annual premium amounts that range from \$1200 per person per year to \$1428. The premiums for similar plans in less competitive markets range from \$1500 per year to \$3500 per year. The savings that could result from competition in these localities could exceed \$200 million per 100,000 people.

BARRIERS TO INTEGRATION

As described earlier, group practices face many barriers on the federal, state and local level to the successful integration of health care services. Below is a list and description of some of those barriers and AGPA's recommendations for reforms:

Antitrust, Fraud and Abuse Laws: In order to organize systems that can comprehensively meet the needs of a population of patients, group practices need clear guidance and flexibility for assembling the necessary elements. Recently published antitrust guidelines are helpful, but they give little guidance for the creation of vertically integrated networks. Strong laws regarding physician ownership and self-referral are needed. The current exceptions in the law are helpful, but continued diligence is necessary to insure that any new laws or regulations do not impair the innovative efforts by group practices. HHS and the IRS also need to carefully apply tax laws for acquisitions so as not to deter efforts at increasing access and improving quality.

Deferred Compensation: OBRA '93 limited the compensation which can be taken into account under a qualified retirement plan. The pension cap was reduced to \$150,000 from its current level of \$235,840. This change limits the ability of tax exempt group practices to recruit physicians because they do not have the same opportunities for deferred compensation under the tax laws as do for-profit entities. It also stifles the collaborative efforts between physician groups and hospitals because physician groups that might otherwise integrate with not-for-profit hospitals will be required to give up significant retirement benefits to which they may be entitled.

Health care institutions organized as not-for-profit corporations have long been the

principle providers of health care services and leaders in the development of new techniques to prevent and treat serious illness. Many are pioneers in cost-effective capitation models and serve inner-city low income populations where physicians share costs for uncompensated care. If not-for-profit institutions and integrated delivery systems are to be fostered, tax laws for deferred compensation must be applied equitably for not-for-profits and for-profit organizations; otherwise for-profit organizations will have a distinct advantage in the health care market.

Tax-exempt status: Many group practices rely on tax exempt financing to support the replacement of capital and the development of new programs and services. These groups have invested in the welfare of their communities through public/private partnerships aimed at expanding access to underserved populations and conducting educational and research programs to improve medical care and innovate medical science. If universal access is achieved in a reformed health care system, group practices have concerns about the criteria that will be used to establish tax-exempt status. To illustrate, we are concerned that the interpretations of "community benefit" may change so that fewer providers are able to achieve tax exemption. This result could significantly impair the development of competitive delivery systems not only because fewer groups may qualify for such status, but because those who still do qualify may encounter a capital market disrupted by changes in the marketplace.

Anti-managed care laws: An important aspect for the creation of integrated delivery systems, especially where the system includes managed care products, are the federal and state laws that regulate the operation of managed care entities. Any-willing-provider laws limit provider selectivity and the ability of a organization to use mechanisms to encourage the use of the cost-conscious, quality driven provider networks. Multiple, and oftentimes redundant quality assurance reviews from the federal and state level are costly and inefficient. Furthermore, state requirements that HMOs offer indemnity products do not recognize the difficulty of establishing such products nor that it is unnecessary for all HMOs to offer all products.

CONCLUSION: GROUP PRACTICE, THE CORNERSTONE FOR REFORM

Recently, Phil Lee, M.D., Assistant Secretary for Health and Human Services, stated that group practices were the "single most important innovation" in American health care delivery.

Medical group practices have the characteristics necessary to be the cornerstones of high quality, cost-effective health care delivery systems. They are physician-led organizations whose main priority is patient care and clinical management. The physician leaders are accustomed to directing health care utilization and then being held accountable by patients, colleagues and payers.

As the nation begins to address more comprehensive ways to meet the growing demands being placed on the health care delivery system, the need for accountability and cost-efficiency are paramount. Fortunately, certain aspects of the health care system already in place will facilitate an orderly transition to a more efficient and accountable health care delivery system. One of them is group practice. We should look to these models and build from them.

Mr. Chairman, AGPA is honored to have the opportunity to appear before you today. We stand ready with the resources of the Association to support your efforts to improve the nation's health care system.

Chairman STARK. Tell you what, if you don't mind, we will recess for just 5 quick minutes and try and make this vote and come right back. And we can do that, or we will get a bunch of bells here, otherwise.

[Recess.]

Chairman STARK. Thank you.

Mr. Serfling, I think you were up next. Do you want to start?

STATEMENT OF JAMES L. REINERTSEN, M.D., VICE PRESIDENT, AMERICAN GROUP PRACTICE ASSOCIATION, AND PRESIDENT AND CHIEF QUALITY OFFICER, HEALTH SYSTEMS MINNESOTA, MINNEAPOLIS, MINN.

Dr. REINERTSEN. Mr. Chairman, my name is James Reinertsen. I am a practicing rheumatologist at the Park Nicollet Medical Center. I am also vice president of American Group Practice Association, and I am the president and chief quality officer of something called Health System Minnesota, which is a community-governed, physician-led care system serving over 300,000 Minnesotans.

I have three principal observations to share with you and your committee today. These are observations from the most advanced managed care marketplace in America. The observations contrast somewhat with testimony given earlier today. And since the twin cities marketplace is—resembles closely what is envisioned for the Nation under some versions of managed competition, the observations might be relevant to those contemplating various reform options.

The first observation is this: Mature, managed care marketplaces, as distinct from early version managed care marketplaces, are producing new kinds of health care systems. I don't think it is fair to say that we can predict the performance of managed competition from the results of the first generation managed care systems which take the existing nonsystem of care delivery and try to discount, inspect, and package it for purchasers.

This produces some short-term savings which really just shift cost to the full price purchasers. The new systems are true care systems, not insurance systems. They bring all care elements under one economic roof, match provider and technology resources to population needs, and reengineer care delivery.

The best of them also free physicians from the innovation stifling effect of fee-for-service or piecework reimbursement systems. They also avoid the ethical problems of paying doctors more for withholding care. Basically, they put physicians on a salary and ask them to do an excellent professional job; and it is really amazing how well that works.

The second observation—

Chairman STARK. You have to grow up, as I did, next door to a guy named Dr. Dako, then move to California where you had the Kaiser Permanente plan to know what good things the Midwest has done.

Dr. REINERTSEN. The second observation is this: This new generation of integrated systems is achieving significant reductions in cost. An example I would cite is the recent collaborative effort with Mayo clinic, Park Nicollet, Group Health, and the Business Health

Care Action Group, a 21-employer group, buying for some 250,000 people.

This group has achieved costs 11 percent below the already efficient Minneapolis-St. Paul market and annual increase rates which approach the CPI; and these aren't false savings either. They are not savings achieved by discounting. They are true cost reductions in the amount of unnecessary service that is being generated. They won't be passed on to others by cost shifting.

We are really changing how medicine is organized, and I can't help but note in passing that those cost reductions are being achieved by the same systems which perennially win the best in class awards by outcomes measures or service measures or any other measure you might wish to look at.

The third observation is this: That the reengineering going on in these new kinds of systems is truly dramatic. For example, breast cancer in our population now is being diagnosed in a curable stage 96 percent of the time because we are able to get out and reach the women who need screening and teach them how to screen and so forth.

Ninety-six percent compares extraordinarily favorably to the standard, if you will, in the United States in nonorganized systems. We now develop guidelines, implement them, and recycle them based on data within weeks and months, not in a matter of years.

The roles in medical manpower requirements are changing at lightning speed. And, basically, what we have discovered is that you don't need 12 years of post-high school education to manage strep throat. There are an enormous number of things we can do now that we have good guideline systems, medical information systems and communication systems to distribute good decisionmaking, even out to patients in their homes rather than always concentrating things in the hands of the physicians.

So as you contemplate all these various reform options, what I would like to have you consider is two observations from this marketplace: First, don't judge the potential of managed care from the performance of primitive systems. Judge from the experience of advanced systems; and, second, if you like what doctors are doing now, then choose a reform option like Medicare based on piecework reimbursement. If you want innovation for quality and efficiency, choose options which allow group practice-based managed care marketplaces to flourish. Stand back and watch the smiles on the faces of the purchasers and the patients.

Thank you.

Chairman STARK. You are suggesting that that would be staff model HMOs with physicians on salary. I think that was the qualifier that you—

Dr. REINERTSEN. I am citing that as the best example. But there may be other innovative examples that would flourish in such a marketplace.

Chairman STARK. I am with you on that, but beyond that it gets complicated.

Mr. Serfling.

STATEMENT OF G. AUBREY SERFLING, PRESIDENT AND CHIEF EXECUTIVE OFFICER, CALIFORNIA PACIFIC MEDICAL CENTER, SAN FRANCISCO, CALIF.

Mr. SERFLING. Yes, Mr. Chairman. I am Aubrey Serfling, president and chief executive officer of California Pacific Medical Center in San Francisco.

I have been a professional health care manager and administrator for my entire working career, and I do appreciate this opportunity to be here this afternoon. CPMC is the second largest private not-for-profit medical center in California, the largest north of Los Angeles. It was formed in 1991 by the merger of Pacific Presbyterian Medical Center and Northern California Health Center, which are the two largest private hospitals in San Francisco. CPMC offers a full continuum of care, including programs in prevention, education, home health, and hospice services, and the full spectrum of acute inpatient and outpatient services. We have 3,390 full-time equivalent employees, 884 active medical staff members, 161 residents, research, and clinical fellows with over \$8 million in associated research grants and \$585 million annually in revenues. Most significantly, we are the leading full service managed care medical center in northern California: with almost 90,000 lives under full capitation, we deliver more high-quality managed health care services than all the other hospitals in San Francisco combined and are second only to the Kaiser system in this regard.

I am here today for three reasons: First, I want to express my strong support for the objectives of the President's health care initiative.

Second, I want to share with you some of the practical experiences of delivering medical care services in a managed care environment regarding cost reduction and the impact of managed care on our employees and patient care programs.

Third, I want to call your attention to a disturbing economic imbalance which will only get worse without the committee's attention: The swelling overhead charges by HMOs and related organizational costs, including those that are burdens for physicians and hospital.

As the medical center administrator, I support President and Mrs. Clinton's sweeping approach to health care reform and the overall objectives of the administration's plan. At 15 percent of the Gross National Product, I also believe this is not a funding problem; it is a structural delivery system problem.

I have seen the health care world change dramatically in my 21 years in this field. Acute care hospitals are no longer the center of the medical universe; and that, at our medical center, we have long since passed the time when we assumed no financial risk for our performance. I am proud to say that I run one of the finest medical centers in the Nation; but even at CPMC, it is clear that the system needs to be fixed, not polished or painted or small changes but systematically fixed at a fundamental level.

Working with our physicians in our community, we have already been able to accomplish a great deal, but there is only so much we can do from within, and we also need help from you.

The changes in our institution have been dramatic over the past several years, and we know that they will only intensify in the immediate future, health care reform or not.

We have reviewed and modified our fundamental mission and objectives at our institution. We have worked collaboratively with our physicians in a way which could serve as a national model. We, physicians in the medical center together, have embraced cost containment as a core value; and we are already achieving reductions. We are nothing short of astonishing. We have reduced our average daily inpatient by 100 patients a day, a 20 percent decline, through aggressive utilization management, we believe, without compromising the quality of care.

In the next 5 years, we project that our census will be reduced by another hundred patients per day, which is the equivalent to an additional 26 percent of existing volume. At a cost of \$1,200 per patient a day, this obviously has produced dramatic results for those who pay for health care. However, there are major job issues that must be considered when weighing the effects of these significant decreases in acute inpatient census. At the time of the merger that created CPMC in June of 1991, we had 4,314 full-time equivalent employees. By 1998, our work force will be reduced by over 40 percent or in excess of 12,000 employees.

In California Pacific Medical Center, our culture has always been care conscious; now it is equally cost conscious. Efficiency and stewardship of resources are a way of life.

On the other side of the coin, I want to share two managed care related concerns. First, as a major medical center, we have worked very hard to build a long list of centers of excellence designed to meet the special needs of our patient populations. Many of them have chronic or catastrophic illnesses that have a devastating personal and financial impact.

There are a number of these programs which I could enumerate; but, in the interest of time, I won't go into that particular level of detail. However, I could mention that we are frequently confronted, and I am regularly now confronted, with a situation where I am receiving advice from sophisticated consultants that refer to these programs, my life's work, as little more than an unacceptable underwriting risk. Increasingly, they are advising the medical center and advising me to diminish our commitment and support to these programs because they encourage people with complicated illnesses to select us and our medical group as their provider of choice during open enrollment.

Chairman STARK. Repeat that. Was Peat Marwick one of those consultants? Or Allen Antobe? Go ahead. Say that one over again. It is music to my ears. But—

Mr. SERFLING. It is really a matter of great concern to me and of great concern to our physicians to have these programs looked at from that vantage point. And it is quite astonishing, I think, to both the doctors and the board.

I know that there is consideration of a balanced assignment of high-risk patients among insurance companies to make sure that they do not select only healthy patient populations. However, I am not aware of an equal commitment, to ensure that those companies reflect in their reimbursement, a differential for the underlying

health status of the patients that select particular providers. This is a must if excellence is to be preserved.

If such a feature is not included in your legislation, major medical centers, like CPMC, will be forced to diminish our commitment to special programs serving very sick patients with more complicated illnesses. This is already happening in California.

Furthermore, I want to take this opportunity to make the subcommittee aware of the implications of Medicare HMO contracting to our organization. When we contract with a Medicare HMO, we lose all medical education reimbursement. I am later informed that the cost of medical education has been included in the calculation of the average area per capita cost, or the AAPCC, reimbursement that a plan receives. Of course, when I meet with these plans, they say there has been no Federal funding that has been identified or that they have received earmarked for medical education. As a result, we were caught in the middle; and for every Medicare patient that chooses to be in an HMO, our institution must forego this reimbursement for medical education as a price of entry.

I would like to close by focusing the subcommittee's attention on an issue which needs to be more forcefully investigated and considered: the extraordinary amount of collective health care resources that pay for the administration and overhead of managed care programs.

In negotiating with third-party payers, specifically the HMOs in northern California, it is very common for these HMOs, through their premium structure, to, in effect, levy a charge to the providers of between 12 and 18 percent of the premium dollar for administration and overhead.

Parenthetically, I will say that we are very sure of this because, in negotiating the Medicare risk contracts, we know exactly what the APC is; we know exactly what we get; we know exactly what the medical group is. And just within the last month, we closed a contract with our largest Medicare HMO in the—off the top, amount of reimbursement they took was 16 percent, and we are bearing 100 percent of the risk, except for the out-of-area emergency services.

In administering such full capitated agreements, in addition, we currently budget between 8 and 10 percent of costs to cover the infrastructure required to implement and maintain and manage these agreements. Thus, I believe between 25 and 30 percent of the health care dollar has gone before it ever gets to a doctor or the hospital.

There is something terribly wrong here. It has been reported that in Kaiser, the Nation's largest provider of managed care, that the cost is approximately 5 percent. I believe that HCFA administers Medicare for slightly less. Some have pointed to these facts in support of a single-payer system, and I must admit on this score, they certainly have a valid issue.

However, I do recognize that private HMOs are key players in the current and future managed care environment envisioned by the President and many in Congress. Certainly we must all be challenged to streamline our operations and become more efficient. However, the administration and overhead costs I described I believe is absolutely unacceptable. It is a major stumbling block to

achieving the goal of a cost-effective, compassionate delivery system. And I hope that this subcommittee takes a hard look at it.

Once again, I want to thank you, Mr. Chairman and your colleagues, for affording me this opportunity to share my perspectives with you. California Pacific Medical Center is a living laboratory of managed care, and I hope our experiences are valuable to this subcommittee as it carries out its vitally important work.

As a matter of fact, I believe that no matter what happens here in Washington, that, at least, for our institution, it may well all be over in terms of a full implementation of a managed care environment before Congress takes action.

[The prepared statement follows:]

**Testimony of
G. Aubrey Serfling
President and CEO
California Pacific Medical Center
San Francisco**

**Subcommittee on Health
U.S. House Ways and Means Committee
February 2, 1994**

Mr. Chairman and Members, I am Aubrey Serfling, President and Chief Executive Officer of California Pacific Medical Center in San Francisco. I have been a professional health care manager and administrator for my entire working career, and I appreciate this opportunity to be here this morning.

CPMC is the second largest private, not-for-profit medical center in California, the largest north of Los Angeles. It was formed in 1991 by the merger of Pacific Presbyterian Medical Center and Northern California Health Center (Children's Hospital of San Francisco). CPMC offers the full continuum of care, including programs in prevention and education, home health and hospice services, and the full spectrum of acute inpatient and outpatient services. We have 3,390 full time employees, 884 active medical staff members, and 161 residents, research and clinical fellows with over \$8 million in associated research grants, and \$585 million in annual revenues. Most significantly, we are the leading full service managed care medical center in Northern California: with almost 90,000 lives under full capitation, we deliver more high quality managed health care than all other hospitals in San Francisco combined, and are second only to the Kaiser system in this regard.

I am here today for three reasons:

First, I want to express my strong support for the objectives of the President's health care initiative.

Second, I want to share with you some of the practical experiences of delivering medical services in a managed care environment regarding cost reduction and the impact of managed care on labor, Centers of Excellence, and support for graduate medical education.

Third, I want to call your attention to a disturbing economic imbalance which will only get worse without this committee's attention -- the swelling overhead charges by HMOs and related institutional costs associated with the administration of managed care programs.

Support for the President's Initiative

As a medical center administrator, I support President and Mrs. Clinton's sweeping approach to health care reform and the overall objectives of the Administration's plan. At 15 percent

of the nation's gross national product, this is not a funding problem, it is a structural problem.

I have seen the health care world change dramatically in my 21 years in this field. Acute care hospitals are no longer the center of the medical universe. We have long since passed the time when we assumed no financial risk for our performance. I'm proud to say that I run one of the finest medical centers in the nation, but even at CPMC it is clear that the system needs to be fixed -- not polished or painted -- but systemically fixed.

Working with our physicians and our community, we have already been able to accomplish a great deal. But there is only so much we can do from within. We also need help from you.

Managed Care Realities

The changes in our institution have been dramatic over the past several years and we know that they will only intensify in the immediate future, health care reform or not.

We have reviewed and modified our fundamental mission and objectives as an institution. We have worked collaboratively with our physicians in a way which could serve as a national model. We, physicians and medical center together, have embraced cost containment as a core value and we are already achieving reductions which are nothing short of astonishing. We have reduced our average daily inpatient census by 100 patients, a 20 percent decline, through aggressive utilization management without compromising the quality of care.

In the next five years, our census will be reduced by another 100 patients per day, equivalent to an additional 26 percent of existing volume. At a cost of \$1,200 per patient day, this obviously has produced dramatic results for those who pay for health care. However, there are major job issues that also must be considered when weighing the effects of the significant decrease in the acute inpatient census. At the time of the merger that created CPMC, in June 1991, we had 4,314 full time employees. By 1998, our work force will be reduced by 40 percent.

At California Pacific Medical Center, our culture has always been care-conscious. Now it is equally cost-conscious. Efficiency and stewardship of resources are a way of life.

On the other side of the coin, I want to share two major managed care-related concerns.

First, as a major medical center, we have worked very hard to build a long list of Centers of Excellence designed to meet the needs of special patient populations. Many of them have chronic or catastrophic illnesses that have a devastating personal and financial impact. These Centers of Excellence include:

- Cancer Care. We provide a continuum of cancer care, including our hospice programs. Our Breast Health Center, a national model that Mrs. Clinton visited last October, provides community outreach, education and prevention, and cost-efficient means of delivering care in ways that are more beneficial for women.
- Pediatric Programs, including pediatric transplant, of which our liver transplant program was rated first nationally by the United Network for Organ Sharing (UNOS).
- Neonatal Intensive Care Unit for high risk newborns: We have been identified by the State of California as having the lowest risk-adjusted mortality in the state.
- An End Stage Heart Disease Program, including our world class transplant facility.
- We are a national model for AIDS care; our Visiting Nurses and Hospice program, another designated Center of Excellence, provides 175,000 home care visits each year.

There are a number of other programs I could mention which provide unique and substantial benefits to those we serve; however, on a regular basis, I am confronted with a situation where I am receiving advice from sophisticated consultants that refer to this, my life's work, as little more than an unacceptable underwriting risk. Increasingly, they are advising the Medical Center to diminish our support and commitment to these programs because they encourage people with complicated illnesses to select us as their provider of choice during open enrollment.

I know that there is consideration of a balanced assignment of high-risk patients among insurance companies to ensure that they do not select only healthy patient populations. However, I am not aware of an equal commitment to ensure that those companies reflect in their reimbursement a differential for the underlying health status of patients that select particular providers.

If such a feature is not included in your legislation, major medical centers (like CPMC) will be forced to diminish our commitment to special programs serving very sick patients with more complicated illness. This is already happening in California.

Further, I want to take this opportunity to make the Subcommittee aware of the implications of Medicare HMO contracting to our organization. When we contract with a Medicare HMO, we lose all medical education reimbursement. I am later informed that the cost of medical education has been included in the calculation of the average area per capita cost reimbursement that a plan receives. Of course, when I later meet with these plans they say there has been no federal funding that they have received that has been earmarked for medical education. The result is that we are caught in the middle, and for every Medicare patient that chooses to be in an HMO, our institution must forego reimbursement for medical education as a price of entry.

Containing Managed Care Administrative Costs

I would like to close by focusing the Subcommittee's attention on an issue which needs to be more forcefully investigated and considered: the extraordinary, and I will even say uncontainable, amount of our collective health care resources that pay for the administration and overhead of managed care programs.

In negotiating with third party payors, specifically the HMOs in Northern California, it is very common for providers to be charged between 12 to 18 percent of the premium dollar for administration and overhead. We are also called upon to assume all financial risk for our performance. To use industry jargon, medical center and physician groups operate under full capitation.

In administering such full capitation agreements, we currently budget approximately 8 to 10 percent in additional costs to cover the infrastructure required to implement these agreements. Thus, between 25 and 30 percent of the health care dollar is gone before it ever gets to the provider of the patient's care.

There's something terribly wrong here. Kaiser, the nation's largest provider of managed care, does so at a cost of approximately 5 percent. HCFA administers Medicare for slightly less. Some have pointed to these facts in support of a single payor system, and I must admit that, on this score, they seem to have a valid issue.

However, I recognize that private HMOs are key players in the current and future managed care environment envisioned by the President and many in Congress. Certainly we must all be challenged to streamline our operations and become more efficient. But the administration and overhead cost situation I described is absolutely unacceptable. It is a major stumbling block to achieving the goal of a cost effective, compassionate delivery system.. And I hope this Subcommittee takes a hard look at it.

Conclusion

I want to thank you, Mr. Chairman and your colleagues for affording me this opportunity to share my perspectives with you. California Pacific Medical Center is a living laboratory of managed care, and I hope our experiences are valuable to this Subcommittee as it carries out its vitally important work.

I would be happy to answer any questions.

Chairman STARK. Well, thank you.

Thank all three of you. I must admit to my prejudices, I grew up in a community in an area where I thought doctors delivered medical care, paper boys delivered the Milwaukee Journal, Gridley delivered the milk; and the world has gotten somewhat more complex since then, probably fortunately so.

For those of you, unlike Mr. Serfling, who don't know the county in which my district exists, it has 1.2 million people. Let's suppose 200,000 of them are Federal employees or uninsured, a half million of them belong to Kaiser, which is arguably more than half, half the people in plant.

Kaiser provides care with about a third the number of doctors and a quarter of the number of hospital rooms that the rest of the medical community in my district provides it.

They are 50 years old, and they have taken on an institutional approach that gives them some community responsibility, but they don't take Medicare patients in open enrollment.

You have got to take a physical exam to get in, and they will turn you down if you smoke. And they have managed over these 50 years to do some fairly good risk selecting, which is understandable. But they probably do operate with a very low overhead and have been able to create some very innovative medical delivery systems, primary care, and preventive care, and do some research that has been, I think, outstanding.

So I have a strong and good feeling. When I moved to California, it should be recognized that going to work for Kaiser was considered, *prima facie*, an unethical behavior on the part of the California Medical Association or you were drummed out of the corps. So attitudes have changed somewhat over a period of time. And now the pendulum has swung.

And, as I say, the shylocks in the insurance business have figured out that if you only get healthy people and if you put somebody in between expensive care and these healthy people, you can make a lot of money.

I don't know what you get for your 16 percent that this HMO skims off the top, but probably a good bit of that goes to some insurance salesman. If that is an issue that we will spend money for, that is something we ought to decide separately.

But what we are faced with is to suddenly say that we are going to take the entire country and shove them into HMOs over a couple of years, and I think that is a formula for disaster.

In South Carolina, around 23 percent of the people belong to HMOs, and you say HMO, and they think you are talking about a sexually transmitted disease. That is not a popular institution.

In some parts of the Midwest where socialism is not a bad word and it is connected with the German heritage, and in some of the wilder parts of the country like California where we do strange things early on, there have been good experiences. I just am concerned that force feeding this idea that we are going to put everybody higgledy-piggledy into a plan in areas where we are not prepared is a formula for disaster.

We have gone through the drill on physician referral; and while it is just a minuscule part of the physician community that abused

it, the abuses were astounding. We have got all kinds of anecdotes about Medicare mills on cataract surgery and the rest of it.

That is such a small number of people, but it is there. And when you get into situations where you deny people care to make a profit, somehow that seems to me to be even worse. I suppose that you can't do a hell of a lot of damage by taking my cataracts out 20 years before you really have to otherwise, assuming that somebody does a good job; and so the taxpayers lose a few dollars.

But denying somebody care, that seems to me a whole lot riskier and socially counterproductive. And that is our concern. And those of you representing groups here could give us a lot of help and say, what do we do? I mean, there have got to be rules, and doctors generally don't like rules, any of them. I mean the best, most conscientious doctors don't like rules. They are just an independent sort of folks, and we are going to have to have some.

We are not getting much guidance out of the President's bill. You heard the testimony this morning. There was a lot of nice, high-sounding phrases; but that doesn't lead us to, wait a minute, who sues whom? Who pays whom? Who sets the rules? What are the rules? Somehow that has got to get done.

And the debate as to whether we do it at the county level or the State level or the Federal level doesn't make much difference. If we can't find good guidelines that we are all comfortable with—you as professionals, us from the standpoint of how much money we are going to spend—we have a problem; and you could give us more help on that.

One question to Dr. Montgomery. Great Falls Clinic in Great Falls, Montana. Good clinic. Don't know them.

Dr. MONTGOMERY. I don't know them.

Chairman STARK. Other than that, I do appreciate your being here, and any help you can give us on how we ought to structure this.

Dr. Reinertsen, I can't disagree with a thing you say. Medicare makes available, by the way, participation to groups. I think we pay a little too much sometimes, but you can join a risk contract as a Medicare beneficiary; and if you don't like it, you can still leave and go to your clinic or go to Mr. Serfling's or go to Mayo's. I always felt that is kind of a safety valve, imperfect as we discussed earlier, but it doesn't lock them in. So I—

Dr. REINERTSEN. If I could, Mr. Chairman, I do have one suggestion. It is based on conversations I had with over 100 practices over the last several years in a number of different practice settings around the country, not only in these unusual organizations like Mayo and Park Nicollet and Kaiser and so forth.

I asked them the question—and of course these were conversations which went like this—if you were paid exactly what you are paid, what you have earned now, but you were at no personal risk for innovating in your practice to do what you think you ought to be doing for your patients in the most efficient possible way for this population of 2,000 patients or whoever you now take care of, what would you do? What would your practice look like? What would you do yourself? What would others do?

And the most innovative sort of stuff came back to me. The doctors would say, first of all, I wouldn't do any immunizations in my

office. It is silly to have a mom and her kids come trooping in the office one by one. We ought to do it out in the community and be organized in that the way we used to do polio, and it worked and it was better documented than it is now, and it got the job done. And they would go on and on like this.

And then I would—they wouldn't manage all the routine colds and flus and the things they don't need 12 years of post-high school education to do. They would have a trained team of people in their system doing that, and they would focus on the tough stuff; and they would spend more time with the tough problems and do a better job of it.

And when I got to the end of it, some of them had tears in their eyes as they described this world. And I said, why don't you just do that. And they said, because I would go broke. I only get paid on a fee-for-service, piecework system, for doing services I personally render. And I said to them, you mean, you are choosing between innovation and better care for the community and going broke? And they said, yes.

Now, these are not bad doctors. That is a bad system.

Chairman STARK. How much do you pay a starting GP or family practitioner in your practice?

Dr. REINERTSEN. In the neighborhood of \$100,000 a year.

Chairman STARK. And Kaiser is paying about, in northern California, maybe 120. And my friends who have private group practices, small groups of primary care said, we can't get anybody. I said, I know why, because, one, the guy has got to eventually invest in your practice, he has got to pay for his share of the furniture and x-ray machine.

Second, as the new kid on the team, he draws, or she draws, all the lousy weekends. You are going to get Thanksgiving and Christmas and New Year's and 4th of July.

This particular person who ran this group practice clinic tells me that all he could afford is about 80. He said, really that is all we could pay.

And so Kaiser down the street in Redwood City will pay 120 with all these things you suggest: no billing, no worry.

I mean, it is a small wonder that there is some popularity in some parts of the country, and these types of practices are going to grow regardless of what we do, regardless. They will grow more slowly in some areas and faster in others. They have been growing. We saw all kinds of charts here. It has nothing to do with our legislation.

And I am just saying, let it grow. Don't try and take this into a hot house. How long did it take to you to try and grow wild rice in Minnesota before you figured out you really couldn't? Years. But darn good stuff when you let it grow and harvest it naturally.

Why not let these things go. Ten years from now there will be twice as many doctors working for salary in managed care, twice as many people in a variety of managed care things that we don't have to legislate at all.

But I am just worried that if we say, within 2 years, 90 percent of the population is going to be in some mandated program, that we are heading for trouble, and I don't think we are prepared to design it. That is my worry.

But we will see, and that is our problem. We have 6 weeks to write a bill, and there is nothing in the President's bill that really lays out the kind of regulations we need. And that is scary.

So whatever you can send us, will be helpful.

Mrs. Johnson.

Mrs. JOHNSON. Thank you.

And thank you for your testimony. Group practices do offer a good deal of insight into how we get from here to the kind of vision that you describe, Dr. Reinertsen.

I certainly would hope, Mr. Serfling, that you would not take the advice of business consultants who see your centers of excellence as an unacceptable underwriting risk. There are other groups throughout the Nation that are finding those centers of excellence are going to be what they will provide to other less sophisticated, integrated systems of care who can't afford to, nor should we want them to duplicate those services.

So you are just ahead of the curve a little bit, and you have got these centers of excellence being fed by your own larger group, which is quite large. On the integrated systems that you speak to, Dr. Montgomery and Dr. Reinertsen, in your testimony on page 3, it is interesting that you talk about how larger multispecialty groups are beginning to work with hospitals and in local communities to create seamless systems of care.

Those seamless systems of care need you, Mr. Serfling, and your organization because they can't be asked to get into the high cost. And some of those systems of care are going to eliminate, currently, rather costly services that are lower utilized.

So the question is less where it is we are trying to go than how it is we are going to get there.

And, Dr. Reinertsen, as much as I think many of these systems will evolve and become capitated systems, I think it would be a mistake to prejudge that. It would certainly be a mistake to put in place a system that is likely to allow only capitated systems, particularly in a short period of time.

Because the only way you are going to be able to get from year one to year five is going to be through big accountable health plans negotiating very low premiums which are going to allow a level of reorganization that is not going to allow the capital investment that the very systems you know work require. So I hate to prejudge that issue of capitation at this point.

Have you no concern yourself about the history of capitation, the history of government-driven capitation? It has under reimbursed so severely, it reduces access and has created, in Connecticut, a 30 percent cost shift.

Now, is that the history you are going to rely on? You look at the developing history of capitation in the private sector—and I am not too familiar with this—and this regionally varies and so on and so forth; but when my mother's doctor, who is a good internist, accepts Medicaid reimbursement rates, doesn't balance the bill, makes house calls, tells me that one of the Nation's big capitated plans wants to pay him \$9 a month for care for a senior, he can't do it; he can't join that capitated system.

So I want to be sure that, in getting from here to there, we deal with the downside of managed groups competing and negotiating as well as the upside of moving in that direction.

I am not very comfortable with capitation right now because I see the same abuses of capitation that you see of HMOs and that you see for fee-for-service in the opposite direction. I would be interested in your comments on capitation.

I appreciate your comments on page 3. And while I am at it, just let me say that the other thing I think you need to enlarge on for us—because this came up in the earlier panels, this is very, very important—on page 6 you say, these efforts will not assure quality care for Americans at a reasonable cost taken out of context or left to stand on their own.

Now, remember the history of government regulation. These performance indicators may perpetuate ways to end inefficiency, and certainly many of the specialty standards of care are going to increase costs, not decrease costs if applied irrationally.

And I am very much concerned that government performance of indicators for you could have a downside consequences. But not being in the business, I would like you to enlarge on that and on the issue of capitation.

Thank you.

Dr. REINERTSEN. I think the key issue with capitation is not capitation itself for a given system but how the capitation economic incentive is translated to the individual physicians and other providers making the care decisions on the day-to-day basis.

If, in fact, individual physicians are paid more for doing more services, as they are in fee-for-service reimbursement, you run the risk that they are going to do too many.

If the individual physician has a personal incentive to withhold care by some mechanism as it is translated down to the individual physician, then you run into that serious problem and all the difficulties that have been cited so well in the past.

So the individual physician, it seems it me, is—if capitation is translate to that level, you get problems.

But where capitation is applied to an entire system and that system just salaries the physicians, for example, the system and its purchasing community have their incentives aligned.

If the patient, the purchasers, and the system then sit down and begin to allocate resources together, set guidelines together, could all these other activities together truly align the incentives and the interests of all the customers?

The other problem with capitation, at least at the Federal level for the Medicare population has well been documented is the extraordinary geographic variation in the AAPLL levels. There are some parts of this country where nobody is trying to get into the Medicare risk contracting business because, at any level of efficiency, you couldn't make out doing that: You couldn't deliver the services.

At other parts of the country, you could give people free televisions and all kinds of incentives to sign up and not have them pay any premium and be—and have a very profitable business on the Medicare.

Mrs. JOHNSON. I didn't realize that. I didn't realize that there was such a variation in Medicare risk contracts.

Dr. REINERTSEN. Basically, the Medicare risk contract payment method rewards those parts of the country that have been least efficient historically in delivering Medicare services and punishes those which have been most efficient.

Mrs. JOHNSON. Interesting. And to this issue, your concern that the government establishing quality indicators and doing all of the other kinds of things that you have heard talked about today could actually be counterproductive.

Could you enlarge on that?

Dr. MONTGOMERY. I think that that is what we are suggesting—that as, I think you suggested earlier, that we not rush into accepting a system that is going to destroy the innovation that groups have and integrated systems have in developing both outcomes and practice parameters and not getting—letting that get hung up in the Federal bureaucracy. And I think that is a real concern that we have.

Mrs. JOHNSON. Well, any further thoughts that you have on how we can, particularly in this case, get from here to there?

I think there is a lot of dissatisfaction on both sides of the aisle with some of the things that are on the table. And we are open to guidance on what are the right incentives to create the right actions with the least dictated involvement from Washington.

I personally am very concerned by what I see happening in Medicare where we have come to the point now where we have charting criteria for office visit reimbursements.

I think that indicates to you that the bureaucracy is perfectly capable of a level of intervention and involvement in patient-doctor situations that would be not only destructive, the evolution of the system into efficient, quality oriented system, but certainly abrogate all standards of privacy that we have hitherto associated with medical care.

Dr. MONTGOMERY. I think the other thing, that doesn't guarantee quality. We can have that system, and we can't prove quality there; and that, I think, is what we need to do.

Mrs. JOHNSON. Thank you.

Chairman STARK. Mr. McCrery.

Mr. MCCRERY. I am sorry I wasn't here for all of your testimony, and you may have covered this; and if so, I apologize.

Do you have any experience in providing service to rural areas where there is low population density or perhaps rural areas where the population is poor or elderly?

And, if so, can you share with us how you have handled that? And does it work?

Dr. MONTGOMERY. Well, we have done that. I am at the Fabgo Clinic which now is called MeritCare because we merged with our hospital about 6 months ago; but we provide care for eastern North Dakota, northwest Minnesota and North and South Dakota. And we have been able to merge and bring in small group practices in towns of 2,000, 4,000, 6,000, and provide care.

Now, we are having more difficulty, as the cost to hire family physicians rises, as their need throughout the country becomes

greater, as people say we need more primary care. We are going to pay more for primary care.

We, as an organization, have had to set up our own locum tenens, for instance, where we can go out and provide the physician in the town of 3,000—and perhaps there is only one or two—we provide him with help and another physician or two on weekends so that he is only taking the same amount of calls that our family practice people in our metropolitan area of 120,000 are taking. We need to do that so the family—the physician's family can exist.

We have also begun to use physician's assistants and nurse practitioners very heavily under the guidance of physicians. We think that is very important.

However, as Dr. Reinertsen suggested, they can provide very good medical care under the guidance of physicians and do things that physicians do. We don't need a 12-year, posteducated person to do it. So we have been able to provide the care in those communities.

We even go out and provide care in clinics 1 day a week to communities of 5,000, or 500, 1,000, out in the farming areas; and we have no—I mean, we use that to get the elderly and everybody else in.

Again, it gets more difficult, and we are beginning to use more allied professionals to help us. But we think that we can still provide very good quality care in doing that.

Mr. MCCRERY. And you have been able to do that financially? I mean—

Dr. MONTGOMERY. Well, at the present time, we are still able to do it financially. We—obviously, if you—we are a system that is very—that 10 years ago, our group practice was very unincentivized from the physician's point of view; that is, almost 80 percent of the physicians made the same amount of money with the top 20 percent of super specialists getting a little bit more.

Then we went to a more production-oriented physician because we had difficulty hiring the super specialist. Now actually, we are backing off, and we are becoming more unincentivized again, paying a pretty much flat rate.

We then need to—because we are not paying the neurosurgeon those high dollars, some of the neurosurgeon dollars actually go off to pay the family practice people who cannot possibly book that much out in the community of 2,000 or 3,000. So far we have been able to financially make it pay. And certainly the use of nurse practical practitioners and PA's has helped out a lot.

Mr. MCCRERY. Anybody else have a comment?

Thank you, Mr. Chairman.

Chairman STARK. Would any other Members like to inquire?

Thank you very much.

Chairman STARK. Again, I would just like to repeat my cry for help. We have got a lot of details to fill in, and any help you could give us, any specific, you know, lists of rules, State regulations that make sense to you, send them on because somehow we have to proceed. We want to try and do it right, not cause more harm than necessary. I appreciate very much your taking the time and the effort to enlighten us today. Thank you very much.

Our final panel includes representatives of managed care plans. We will hear from Karen Ignagni, president and CEO of the Group Health Association of America; Dr. Donald Schaller, the senior vice president of Managed Care Programs for Samaritan Health Systems in Phoenix, Ariz.; Jay Harrington, president and CEO of the Neighbor Health Plan in Boston, Mass.; and Thomas Smith, chief operating officer of the Community Health Group of Chula Vista, Calif.

We welcome the witnesses to the committee and ask you to summarize or expand on your statement.

Mrs. Ignagni, lead off.

STATEMENT OF KAREN IGNAGNI, PRESIDENT AND CHIEF EXECUTIVE OFFICER, GROUP HEALTH ASSOCIATION OF AMERICA

Ms. IGNAGNI. I thank you, Mr. Chairman.

I have a bout—I must apologize in advance. I have a bout of the flu.

Mr. Chairman and members of the subcommittee, thank you for the opportunity to appear before you this afternoon. I am Karen Ignagni, president of the Group Health Association of America, representing 350 health maintenance organizations with approximately 35 million members.

HMO enrollment, as you undoubtedly know and have been discussing today, has quadrupled over the past decade alone. Today about 45 million people—roughly about one out of every five Americans who have health insurance—are enrolled in HMOs, and we estimate that that enrollment will exceed 50 million by the end of 1994.

What is it about HMOs that make them attractive to members? Lower cost is certainly one answer, but that is only part of the answer. HMOs organize the delivery of comprehensive health care in a way that simply makes a great deal of sense to many Americans. They like having a primary care physician who knows their needs and who represents their first line of defense against illness. They like knowing that their primary care physician will arrange for treatment by specialists. And they like the idea that a single annual premium will cover all of their needs, regardless of the costs they may incur.

They also like having various HMO models to choose from. HMOs offer exceptionally good value. They cover more services than fee-for-service plans, usually with no deductibles, and with minimal copayments, an important point to keep in mind in making cost comparisons. And HMOs emphasize preventive care services. They promote quality in many ways, including careful selection of providers, based on professional qualifications, documented evidence with regard to patient outcomes, and interest in working within a coordinated health care system. Eighty-five percent of HMO physicians are board certified compared to 60 percent of physicians nationwide.

And unlike most fee-for-service indemnity plans, HMO plans routinely monitor and analyze clinical practices and patient outcomes. They use this information to improve quality and cost-effectiveness

of care, which requires active coordination of services, active attention to detail, and active consumer education.

As the General Accounting Office and some other investigators have found, it is difficult to measure the ability of HMOs and other managed care plans to contain the seemingly inexorable rise in health care costs overall.

As a result, some policymakers have concluded that HMOs may not, in fact, contain health care costs. There are at least three reasons why such a conclusion is unwarranted. First, there is ample evidence that in situations they can control, HMOs do control costs. Preventive care reduces hospitalizations, and every hospitalization that can be avoided without compromising care represents a savings.

An HMO can thus have a significant impact, over time, on total health care costs of the total population it serves.

Second, HMOs reduce costs down more effectively as the size of total enrolled population increases. That is the spillover effect that so many economists have written about recently.

Third, evidence is accumulating that HMOs are, in fact, helping to restrain the growth in overall health care costs, confirming that they offer great promise as a long-term cost containment tool.

Several months ago, we asked Peat Marwick & Company to conduct an independent study of increases in health care premiums from 1988 to 1993.

In their report, which was released earlier this week, the researchers confirmed that HMO premiums have been increasing more slowly than fee-for-service or preferred-provider premiums.

Questions have sometimes been raised about whether HMOs offer more than a one-time savings, attributable to lower hospitalization rates. The Peat Marwick researchers found that, in fact, HMOs offer savings that accumulate over time.

Policymakers will have an opportunity to see the savings even more clearly when a system of comparable performance measures for health plans is in place.

We support the concept of report cards embodied in President Clinton's health plan and, indeed, have moved actively with a number of our plans with employers and consumer groups to move forward in developing such report cards.

Assuming that Congress enacts legislation extending health coverage protection to all Americans—and we believe that you should with dispatch it is important to understand the role that HMOs can play in providing quality health care to currently uninsured households at reasonable costs. No health care system can be a panacea, but we believe the best way to begin overcoming the kinds of obstacles that people have faced in terms of barriers to entry in the health care system is to provide patients with a qualified primary care physician at the core of an integrated system of care.

Concerns have been raised that Medicaid recipients will be forced into HMOs because HMOs are likely to be the lowest cost of the various plans offered under health care reform.

Our response is to reiterate that we believe strongly that all consumers should be free to choose among competing health plans on the basis of quality and convenience as well as price.

We certainly can't expect to contain long-term costs as long as large numbers of Americans are floundering outside of existing health care delivery systems or otherwise unable to avail themselves of its best practices.

By design, HMOs are inherently inclusive practitioners of comprehensive, coordinated, high-quality care at predictable costs. In our view, that makes them a natural fit with reform. We would be pleased to answer any of your questions.

Thank you very much.

Chairman STARK. Thank you.

[The prepared statement follows:]

**TESTIMONY OF KAREN IGNAGNI
GROUP HEALTH ASSOCIATION OF AMERICA**

Mr. Chairman and members of the Subcommittee, thank you for the opportunity to appear here today to discuss issues related to managed care and health maintenance organizations. I am Karen Ignagni, President and Chief Executive Officer of the Group Health Association of America. GHAA represents 350 health maintenance organizations with 33 million members who account for about 75 percent of total HMO enrollment.

HMOs provide integrated, coordinated, high-quality health care at predictable cost to consumers who consistently give HMOs positive reviews, which are reflected in high enrollment renewal rates. The HMO Act of 1973 was predicated on the belief that HMOs represent a logical way to integrate the financing and delivery of health care. That belief has been borne out.

HMO enrollment has quadrupled during the past decade alone. Today about 45 million people — roughly one out of every five Americans who have health insurance — are enrolled in HMOs, and GHAA estimates that HMO enrollment will exceed 50 million by the end of 1994.

What is it about HMOs that makes them attractive? Lower cost is one answer. But I would argue that it is not *the* answer, and that there is a larger point: HMOs organize the delivery of comprehensive health care in a way that simply makes a great deal of sense to many Americans. I want to speak to that point briefly before returning to questions of cost.

What do HMO members like? They like having a primary care physician who knows their needs and who represents their first line of defense against illness. They like knowing that their primary care physician will arrange for treatment by specialists when necessary. And they like the idea that costs for health care are predictable and coverage is comprehensive.

They also like having various HMO models to choose from. Some consumers prefer the staff or group model, in which physicians and outpatient services are usually provided in the HMO's own centers. Others prefer the independent practice association (IPA) model, in which patients see physicians in their own offices. Increasingly, consumers can also choose plans offering a point-of-service (POS) option that allows them, at additional cost, to select unaffiliated physicians.

GHAA and its member plans have long insisted that consumers be offered the right to consider other kinds of health coverage, including fee-for-service (FFS) insurance plans, *before* they choose an HMO, and furthermore that enrollees be given periodic opportunities to consider alternative plans. Aside from the fact that consumers deserve this protection, it simply makes good sense to ensure that enrollment in HMOs is truly voluntary and firmly based on understanding how HMOs work.

HMOs offer exceptionally good value. As a rule, HMOs cover more services than fee-for-service plans, usually with no deductibles and with minimal copayments — an important point to keep in mind in making cost comparisons. And HMOs emphasize preventive care services: 93 percent of HMO enrollees are covered for routine physical exams, for example, compared to 43 percent of fee-for-service plan participants; more than 90 percent of HMO enrollees are in plans covering well-baby care, compared to less than 60 percent of fee-for-service participants. HMO coverage for illness is similarly comprehensive: 90 percent of HMO enrollees are

covered for skilled nursing and hospice care, for example, compared to 80 percent of fee-for-service participants.

HMOs promote quality in many ways, including careful selection of providers based on professional qualifications, and interest in working within a coordinated care system. Eighty-five percent of HMO physicians are board-certified, compared to 60 percent of physicians nationwide. And unlike most fee-for-service plans, HMO plans routinely monitor and analyze clinical practices and patient outcomes. They use this information to improve the quality and cost-effectiveness of care.

What do I mean by cost-effective care? I think of it as the systematic provision of all medically necessary services to all members of an enrolled household in a way that promotes wellness and emphasizes reliance on best practices to control illness and improve outcomes. High-quality, cost-effective care requires active coordination of services, active attention to detail, and active consumer education. What it is *not* is haphazard, inefficient, inherently costly care of the kind that has been fostered for so long under traditional fee-for-service approaches.

The fact that HMOs offer cost-effective care makes them attractive vehicles with which to deliver quality health care to currently uninsured populations. Today many uninsured women get substandard prenatal care or none at all. Yet a Rand Corp. study published January 15 showed that HMOs were rated above the national average in the delivery of key prenatal services. Many uninsured men and women never see a doctor until an unmonitored illness finally sends them to a hospital emergency room — the costliest place to provide care and the poorest way to provide for continuity of care. The nation as a whole pays dearly for the long-term consequences of such haphazard care. HMOs, with their emphasis on coordination of care and with their capacity for consumer education, represent a logical solution to these kinds of problems.

Let's be clear about the difference between cost-effectiveness and cost containment. Cost-effectiveness, as I've suggested, means delivering all necessary care to all enrollees and their dependents as competently and efficiently as possible. It means that a dollar paid in HMO premiums goes further than a dollar paid for other service models.

As the General Accounting Office and some other investigators have found, it's more difficult to measure the ability of HMOs and other managed care plans to contain the seemingly inexorable rise in health care costs overall. As a result, some policymakers seem to have concluded that HMOs may not, in fact, contain such costs. There are at least three reasons why such a conclusion is unwarranted.

First, there is ample evidence that in situations which they can control, HMOs do contain costs. Preventive care reduces hospitalizations, and every hospitalization that can be avoided without compromising care represents a savings. An HMO can thus have a significant impact, over time, on the total health care costs of the defined population that it serves. Adjusted for health status, hospital utilization rates for HMOs as a group are 30 percent lower than for the population as a whole. Putting that another way, U.S. health care outlays last year would have been about \$6 billion higher if HMOs had been hospitalizing patients at nationwide rates.

Second, the impact of HMOs on physician practice patterns increases as the size of the total HMO-enrolled population grows and this helps to moderate cost increases. Ten years ago, when HMOs served less than 10 percent of the U.S. population, their leverage was quite limited. Now that

they serve nearly 20 percent of the population, they have twice as much leverage — but that still gives them relatively little ability to impact health care costs overall, since 80 percent of the U.S. population remains outside the HMO universe.

To illustrate what can be expected to happen as more Americans join HMOs, consider the area of chronic care for the elderly. The Group Health Foundation, in an ongoing study of chronic care initiatives among HMOs, has found that the HMO structure lends itself particularly well to serving the growing numbers of elderly people who need chronic care. Some HMOs, for example, provide exemplary needs-assessment services that go well beyond immediate clinical problems to identify other barriers to needed care, such as lack of transportation, and help provide ways to deal with such problems.

Similarly, HMOs can provide intense primary care to long-term nursing home residents, reducing the number of inappropriate hospital stays and emergency room visits. By actively coordinating the care of post-acute patients requiring physical rehabilitation, HMOs can minimize the risk of further deterioration in functional status. Through case management and coordination of support groups, HMOs promote wellness by helping people who are in crisis. These kinds of initiatives, all of which are being practiced by HMOs every day, help to contain chronic care costs among HMO enrollees and, as more Americans join HMOs, can help to contain overall U.S. outlays for chronic care.

Third, evidence is accumulating that HMOs are, in fact, helping to constrain the growth in overall U.S. health care costs, confirming that HMOs offer great promise as a long-term cost-containment tool.

Several months ago, GHAA retained KPMG Peat Marwick to conduct an independent study of increases in health care premiums from 1988 to 1993. In their report, which was released earlier this week, the researchers found that HMO premiums have been increasing more slowly than fee-for-service or preferred provider organization (PPO) premiums.

As the researchers noted, the gap is actually wider than indicated by premium increase comparisons alone, because HMOs offer a richer package of benefits per premium dollar and because deductibles under fee-for-service (FFS) plans have risen substantially — 59 percent for individuals and 52 percent for family coverage — while most HMOs have continued to require no deductibles at all and only small copayments for office visits.

Furthermore, while HMOs customarily provide immediate coverage for new enrollees with pre-existing conditions, the researchers found that 63 percent of new fee-for-service enrollees must go without payment for coverage for pre-existing conditions, usually for nine to ten months. That represents a substantial gap in coverage, and potentially high out-of-pocket costs for new FFS enrollees.

Questions have sometimes been raised about whether HMOs offer more than a one-time savings attributable to lower hospitalization rates. The KPMG Peat Marwick researchers found that, in fact, HMOs offer savings that accumulate over time.

From 1988 to 1993, HMO premiums increased at a slower rate than either FFS or PPO premiums. For families, HMO premiums rose on average from \$225 per month to \$416 per month, an 84.9 percent increase. For families in fee-for-service plans, premiums rose on average from \$186

per month to \$439 per month, a 136 percent increase. For families in PPO plans, premiums rose on average from \$207 per month to \$436 per month, a 110.6 percent increase.

Annualized, HMO premiums rose 13.1 percent during this period, while PPO premiums rose 16.1 percent and FFS premiums rose 18.7 percent. A difference of three to five percentage points, extended over time, means substantial differences in premium costs, as the KPMG Peat Marwick report notes. Using the annual rates of increase for each of the plan types from 1988 to 1993, and extrapolating that curve over the next decade, the researchers found that in just ten years the cost of FFS coverage would be 60 percent higher than HMO coverage.

There are obvious risks, of course, in extrapolating from the past to predict the future, particularly at a time when the entire structure of health care delivery is under review. But the significance of the KPMG Peat Marwick study is that it clearly and unmistakably lays to rest the misperception that HMOs offer only a one-time savings.

Policymakers will have an opportunity to see the savings even more clearly when a system of comparable performance measures for health plans is in place. GHAA supports the concept of "report cards" embodied in President Clinton's health plan. In cooperation with the independent National Committee for Quality Assurance, GHAA member plans have been at work for some time on developing and refining such a system. Report cards will show how HMOs are containing costs without compromising quality by (1) using preventive care to reduce the frequency of episodes of acute illness and (2) coordinating care to minimize the unnecessary use of discretionary tests and services.

The development and refinement of meaningful rather than potentially misleading report cards requires extremely sophisticated data collection and analysis, a process that inevitably takes time. But we are confident that within a few years report cards will become not only a major consumer education tool but an important cost containment tool as well. They will demonstrate the cost-effectiveness of preventive care and consumer outreach and will create new incentives to maximize outcomes rather than the number of services performed. And they will enhance the ability of HMOs to compete on the basis of quality as well as price.

Assuming that Congress enacts legislation extending health coverage protection to all Americans, it is important to understand the role that HMOs can play in providing quality health care to currently uninsured households at reasonable cost. Societal, environmental and economic factors such as poverty, poor transportation, poor housing, drug abuse, domestic violence and violent crime all complicate the delivery of health care. No health care delivery system can be a panacea, but we believe that the best way to begin overcoming these kinds of obstacles is to provide patients with a qualified primary care physician at the core of an integrated system of care designed to address the special needs of this population.

People without access to or a relationship with a primary care practitioner are prone to seek health care on an episodic basis and in less than optimum settings, often in situations that could have been prevented and with no coordinated follow-up.

Concerns have been raised that Medicaid recipients will be "forced" into HMOs because HMOs are likely to be the lowest-cost of the various plans offered under health care reform. Our response is to reiterate that we believe strongly that *all* consumers should be free to choose among

competing health plans on the basis of quality and convenience as well as price. We also believe, however, that an integrated system of care, which emphasizes prevention and early intervention and which provides prescription drugs and needed support services, can be the best option for high-risk populations, especially those populations that have had limited experience with a health care delivery system.

As part of their integrated approach to health care, HMOs offer a continuing program of preventive and primary health care that includes early and periodic screening, diagnostic and treatment procedures, substance abuse treatment programs, family planning and reproductive health services, and case management practices that help participants to develop trusting relationships with care providers. All of these contribute to cost containment as well as quality; indeed, improved quality of care and long-term cost containment are virtually inseparable in this context.

It should be noted that HMOs have not waited for health care reform to improve their outreach to traditionally underserved populations. In several inner-city settings, HMOs provide exemplary case management for high-risk pregnancies and for patients struggling with substance abuse problems. Clearly, there is a lot more that HMOs and other managed care plans can do and are to reach out beyond their enrolled populations to help others, especially the homeless, with programs such as vaccinations and vision screening for children living in shelters.

This, too, is cost-effective care. The more HMOs have learned about outreach, the more they have been reinforced in their belief that consumer education, preventive care, and coordinated care are crucial to the success of health care reform. Indeed, it seems clear to us that any system of health care reform and universal health care coverage must promote integrated care, since nothing less will bring costs under control while guaranteeing every American the right to comprehensive health care.

We certainly can't expect to contain long-term costs as long as large numbers of Americans are floundering outside the existing health care delivery system or otherwise unable to avail themselves of its best practices. By design, HMOs are inherently inclusive practitioners of comprehensive, coordinated, high-quality health care at predictable cost. That makes them a natural fit with reform.

Thank you.

Chairman STARK. Mr. Schaller.

**STATEMENT OF DONALD F. SCHALLER, M.D., PHOENIX, ARIZ.,
ON BEHALF OF THE ARIZONA HEALTH CARE COST CONTAIN-
MENT SYSTEM**

Dr. SCHALLER. Yes, sir.

Mr. Chairman, thank you for inviting me. I would point out that I am here at the request of Dr. Mabel Chen, who is the current director of the AHCCCS program in Arizona. She was unable to appear, and she asked me to come in her stead, and she sends her apologies.

I prepared some written remarks, but I would like to outline a few points in there if I may.

My background includes 15 years as a fee-for-service family physician in Arizona and 11 years as a medical director of a commercial HMO in the Phoenix area and, then in a change of direction, 3 years as director of the AHCCCS program, which is the acronym for the Arizona Health Care Cost Containment System; and this started in 1984 when Arizona took over the program. And I continued until the end of Governor Babbitt's term. And currently, I am head of a management firm which manages one of the largest, if not the largest, Medicaid-only HMO in the country with 145,000 members.

I was asked to address basically about four areas: One is some history—some elements of history and current status of the AHCCCS program, managed care and Medicaid; some issues revolving around the quality of care within the Medicaid population; some points on the rural models that we have in Arizona; and some comments about the Native Americans and their relationship to this program.

If you have a copy of my paper, on page—on the second sheet, which is not page 2, is a current table that shows the existing enrollment in the program. You will note there are 472,729 members currently. And of those, 37,030 are in the "State-Only" category. The rest are covered under the categorical areas of Title XIX.

I am a supporter of the principle of managed care and I feel that the unique characteristics of a Medicaid population almost dictate that the best provider in a situation like this is a managed care setting, simply because of the characteristics of the Medicaid population; and some of those are on page 2.

We have found that one Medicaid enrollee is equivalent in utilization to about three commercial patients in a commercial HMO. In other words, this is a program where there is, indeed, adverse selection by patients who are sick in their beginning of the eligibility program.

And as you can see, the characteristics of the demographics of the population have changed. And now, in our managed care plan, 64.3 percent of the enrollees are children under 18; 27 percent of the population are women; and only 8.5 percent—that is a typo in the paper—are men.

This population has historically used the emergency room as their primary care physician, as I know you are aware; and the framework of a managed care setting has permitted us to teach

these patients that that is the worst use of resources and probably the source of very poor but episodic care for those patients.

So in the managed care setting that we have, we have been able to teach those patients that, indeed, a better way is to find a primary care physician. And if the patient doesn't select a primary physician, we assign them to one after 3 days of enrollment in our plan.

The other characteristic is the mandated EPSDT services, which I know you understand is the Early Periodic Screenings Diagnosis and Treatment for children. There are other characteristics; but I think, in essence, as you review this program, you can find some of the elements of the rural care, Native Americans, and the quality assurance process in our program which have been a concern of ours since the very beginning of the program.

In fact, we conducted the first State-wide analysis of physician's offices, medical records, and some paradigms in the third year of the program back in 1980-84.

With that, I will close these remarks and be willing to answer any questions you might have.

Thank you.

Chairman STARK. Thank you very much. And if I can find my list here, I will see who is next.

[The prepared statement follows:]

**TESTIMONY OF DONALD F. SCHALLER, M.D.
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM**

Mr. Chairman and members of the subcommittee. I thank you for the opportunity to appear before you today to discuss issues related to managed care, Medicaid and the Arizona Health Care Cost Containment System (AHCCCS), the Title XIX agency for the State of Arizona. Dr. Mabel Chen, the Director of AHCCCS was unable to appear because of some urgent legislation relating to the AHCCCS program that is pending before the Arizona Legislature. She asked me to convey her regrets and to appear on her behalf.

I am Donald F. Schaller, M.D., a family physician from Phoenix. My background includes:

- o 15 years as a fee-for-service family physician in central Phoenix.
- o 11 years as medical director of an HMO (called a Health Care Service Organization (HCSO) in Arizona Statutes).
- o 3 years as Director of AHCCCS (under Governor Bruce Rabbitt) starting in 1984 when Arizona took over the program from a private administrator.
- o 5 years as head of a management firm which manages the largest AHCCCS plan (AP/IPA) for its 2 hospital owners.

I apologize for the format of this testimony, but I only learned yesterday (my travel day from Phoenix) of the request for written testimony.

The issue addressed in these remarks will include:

- o Managed Care: Role in providing service and care to the Medicaid population.
- o Managed Care and Medicaid: Cost effectiveness and consumer satisfaction.
- o Quality Management Directions in AHCCCS.
- o Rural Models in AHCCCS.
- o Native Americans in AHCCCS.

But first, some background and updates on AHCCCS. The program began in 1982. Its early problems are legend and are now overcome. Past reports by Stanford Research (SRI International), Laguna Research Associates, and the GAO have documented these issues.

The current enrollment in AHCCCS is 472,729. (January 1, 1994) see table #1. Care is provided by 14 health plans which bid a competitive rate for each of the categories

TABLE 1

Source: AHCCCS Enrollment Tables as of January 1, 1994

	TITLE XIX	STATE-ONLY	TOTAL
Acute Care	417,566	37,030	454,596
Arizona Long Term Care System	18,133	- 0 -	18,133
TOTAL	435,699	37,030	472,729

of eligible persons in AHCCCS. It should be noted that there are 6 health plans which provide service in rural areas only and their enrollees number from 1634 to 12,700 persons. There are 5 health plans which provide service primarily, if not wholly, urban residents. Two of these are owned by the urban counties of Pima (Tucson) and Maricopa (Phoenix). There are 3 plans which provide service to both urban and rural residents. See tables 2, 3, and 4.

THE ISSUES:

Managed Care: Role in providing service and care to the Medicaid population.

The demographics, the make up, the sick care and health needs, and finally the statutory mandates of the Medicaid population create a unique population which demands a strong regulatory environment, effective care management and broad coverage. Consider these characteristics:

- o Each Medicaid patient is equivalent to 3 commercial enrollees in terms of overall utilization.
- o The population in AP/IPA is made up of:

children under 18	- 64.3%
women	- 27.2%
men	- 85%
- o Commercial HMOs experience 23 deliveries per 1,000 enrollees, while Medicaid plans experience 75 deliveries per 1,000.
- o Historically Medicaid enrollees have utilized hospital emergency rooms as their primary care physicians.
- o Early periodic screening, diagnosis and treatment (EPSDT) services are mandated for Medicaid recipients under age 18.
- o Incidence of pregnancy in young women under 20 years of age is 36% among the AP/IPA Medicaid enrollees compared to 12.8% of the total U.S. population. (table 5).

These and other characteristics dictate the need for:

- o A management umbrella over hospital, physician, and other services which can both shift financial risk through capitation and assure performance by those providers through contract terms .

- o A strong and skilled regulatory body which understands how care can be managed, how patient education can change behavior, and how to monitor plan performance to assure fiscal solvency. It is my view that the early California prepaid practice problems, the early AHCCCS difficulties and the IMC issues could have been avoided through a skilled and vigorous regulatory agency. AHCCCS is that now. Each of those events occurred during the start up and learning phase for the individual states involved.

Traditional state insurance departments and/or state health Departments are ill prepared to regulate the vigorous competitive environment of a statewide Medicaid Managed Care program. A health plan can get into fiscal problems in less than a year, and the regulator must be on top of the curve in detection of irregularities.

- o Change in the Medicaid Eligibility process. AHCCCS does not determine eligibility of any person. Other agencies are responsible. However, the process is personally degrading (21 pages of questions). AHCCCS grants eligibility for 6 months on the first application, but in spite of this, AP/IPA must process over 20,000 persons' paperwork each month - i.e., 10,000 additions and 10,000 deletions just to maintain current enrollment and must confirm eligibility at each visit. This would make it nearly impossible for the solo or small group physician to confirm eligibility for each patient visit.

Quality of Care

Concerns about quality of care for the AHCCCS enrollees has been expressed since the early years of the program. Medical audits with sample sizes that were statistically valid occurred in years 3, 4 & 5. These were the first statewide medical audits of a Medicaid program in the United States.

In year 4, the audit consisted of 5 components. These included:

1. Medical record review - 1,431 medical records representing care by 99 primary care physicians
2. Provide site evaluation - 25 elements to evaluate a reviewed physicians office (93 offices)
3. EPSDT review - 1,509 pediatric records at 80 provider sites
4. A low Back Pain Paradigm
5. Hypertension Paradigm

As time passed the emphasis changed from quality assurance to quality improvement.

- o NCQA accreditation is now a goal of most AHCCCS Plans. 4 plans have completed an NCQA accreditation survey. More are scheduled.
- o Additionally AHCCCS incorporated and adapted QARI Standards into the year AHCCCS XIII Quality Management plan.
- o Now plans are developing "outcome indicators for statewide reporting."
- o Reviews by both SRI and the GAO have confirmed that the quality of care under AHCCCS was in greater conformance with generally accepted Arizona Association of Pediatrics guidelines when compared with New Mexico.

Rural Issues

Rural Arizona is included in the coverage of Medicaid eligible persons. As noted in tables 2, 3 and 4, 6 Health Plans provide service in rural counties only, and 3 other plans provide service in rural, as well as some urban areas. For the most part rural primary care physicians are capitated, and specialists are generally paid on fee-for-service system.

One large plan pays its primary care obstetricians a fixed fee for the entire pregnancy including prenatal, delivery, and post natal care regardless of whether a caesarean section or a normal spontaneous delivery occurs. That plan (AP/IPA) also operates a teen pregnancy program which has resulted in both a lower percentage of births under 25,400 gms and gestation under 37 weeks. These percentages are lower than both the United States and Arizona averages for that population (See table 5).

AP/IPA's statewide enrollment and distribution of physicians under contract are presented in tables 6 and 7.

Another program operational in Cochise County is a rural network operated by 8 primary care physicians. That group assumes the risk of all services provided in that county for a percent of the premium. They accept the risk for inpatient services, physician services, prescriptions, ambulance service - any service within the county. The health plan assumes the cost of administration, enrollment and any tertiary care required at the larger centers in Tuscon or Phoenix. Such as burns, sick newborns or cardiac surgery. 85% of all licensed physicians in the state are registered providers in the AHCCCS program.

Native Americans

Of all the Native Americans in the country about 10% live within the Arizona borders and an estimated 33% of the on-reservation Native Americans live on one of 26 reservations in Arizona. Yet these citizens can be eligible for Medicaid. No accurate count exists of the total number of native Americans in Arizona.

For those Native Americans who live on a reservation, there is a choice of any one of the 14 AHCCCS plans that provide service in the area around or within the reservation. In addition, they have the added option of choosing the Indian Health Service (IHS).

Off reservation, Native Americans have the option of choosing one of the area health plans. Payment is based upon the 65-35% federal match paid by the IHS.

Those Native Americans who are categorically eligible through any of the standard categorical programs, such as SSI, choose one of the AHCCCS health plans on the IHS.

Currently the IHS, the tribes in Arizona and AHCCCS are beginning negotiations on a specific Native American managed care program. Details of this program are not yet available.

TABLE 2
PARTICIPATING HEALTH PLANS

Health Plan Name	Owner	Ownership/ Corporate Structure	Number of Years as AHCCCS Provider	Counties Served	Enrollment	Service Model
AHCCCS Select	Intergroup of Arizona, a publicity held corporation	Corporation for profit	1 year	Maricopa Pima	AHCCCS Acute 16,227 ALTCS N/A Commercial 235,000 Total 251,227	IPA, group
Arizona Physicians IPA	Samaritan Health Services and Tucson Medical Center	Corporation, not for profit	11 years	Cochise, Coconino, Gila, Graham, Greenlee, La Paz, Maricopa, Mohave, Navajo, Pima, Pinal, Santa Cruz, Yavapai, Yuma	AHCCCS Acute 109,306 ALTCS 306 Commercial 850 Total 110,462	IPA
Maricopa County Health Plan	Maricopa County Government	Government, not for profit	11 years	Maricopa	AHCCCS Acute 31,321 ALTCS 5,982 Commercial 0 Total 37,283	Staff
Mercy Care Plan	St. Joseph's Hospital, Phoenix (49%) Carondelet Health Care Group, Tucson (51%)	Corporation, not for profit	10 years	Cochise, Maricopa, Pima, Pinal, Santa Cruz	AHCCCS Acute 61,495 ALTCS N/A Commercial 3,800 Total 65,295	IPA
Phoenix Health Plan	PMH Primary Care, Inc. (Phoenix Memorial Hospital)	Corporation, not for profit	9 years	Maricopa Pinal, parts of	AHCCCS/Acute 28,613 ALTCS N/A Commercial 1,600 Total 30,213	IPA

Note: Plans that do not serve the ALTCS population are denoted in the enrollment column as N/A.

TABLE 3 NON-PARTICIPATING PLANS

Health Plan Name	Owner	Ownership/ Corporate Structure	Number of Years as AHCCCS Provider	Counties Served	Enrollment	Service Model
Regional AHCCCS Health Plan	Casa Grande Regional Hospital	Corporation, not for profit	4 years	Maricopa, part of Pinal	AHCCCS Acute 7,772 ALTCS N/A Commercial 5,000 Total 12,772	IPA
Doctor's Health Plan	Six rural Arizona physicians	Corporation for profit	10 years	Graham	AHCCCS Acute 2,223 ALTCS N/A Commercial 0 Total 2,223	IPA
Arizona Health Concepts	A group of two Arizona physicians and one investor	Corporation, for profit	1 year	La Paz, Mohave, Yavapai	AHCCCS Acute 11,709 ALTCS N/A Commercial 0 Total 11,709	IPA
Health Choice Arizona	Summit Health Ltd.	Corporation, for profit	3 years	Maricopa, Pima, Pinal, parts of	AHCCCS Acute 13,102 ALTCS N/A Commercial 0 Total 13,102	IPA
Family Health Plan of Northeastern Arizona	Group of eleven rural Arizona Physicians	Corporation, for profit	9 years	Gila, Apache, parts of Navajo, Pinal, parts of	AHCCCS Acute 4,397 ALTCS N/A Commercial 0 Total 4,397	IPA
Samaritan Health Systems	Samaritan Health Systems	Corporation, for profit	11 years	Apache	AHCCCS Acute 1,634 ALTCS N/A Commercial 0 Total 1,634	IPA
Pima Health Systems	Pima County Government	Government, not for profit	11 years	Pima	AHCCCS Acute 10,874 ALTCS 1,839 Commercial 0 Total 12,713	IPA

Health Plan Name	Owner	Ownership/ Corporate Structure	Number of Years as AHCCCS Provider	Counties Served	Enrollment	Service Model
Comprehensive AHCCCS Plan	Flagstaff Medical Center	Corporation, not for profit	11 years	Coconino Yavapai, parts of	AHCCCS Acute ALTCS Commercial Total 4,593 87 0 4,680	IPA
St. Luke's Advantage	St. Luke's Health System, Inc.	Corporation, not for profit	3 years	Maricopa	AHCCCS Acute ALTCS Commercial Total 10,527 N/A 0 10,527	IPA

Note: Plans that do not serve the ALTCS population are denoted in the enrollment column as N/A.

TABLE 5
United States, Arizona, APIPA
Comparison of selected characteristics
Babies born to mothers under age 20

	<i>Outcomes</i>					
	Total # Live Births	% All Births	Birthweight < 2500 Grams	Gestational Age < 37 Weeks	Age at Delivery	Age at Delivery
<i>United States</i>	533,483	12.8	49,869	9.3	NA	8,482
<i>Arizona</i>	10,108	14.9*	839	8.3	1,583	NA
<i>APIPA</i>	2,639	26	205	7.8	253	27
						1

NA - data not available

U.S. data for 1990

Arizona data for 1991

APIPA data for 1992

*68,040 total live births reported for 1991



10/19/92 11.1

(Sources: CDC/National Center for Health Statistics; ADHS; APIPA Perinatal Tracking System)

TABLE 6
ARIZONA PHYSICIANS IPA, INC.
Member enrollment - July 1, 1993

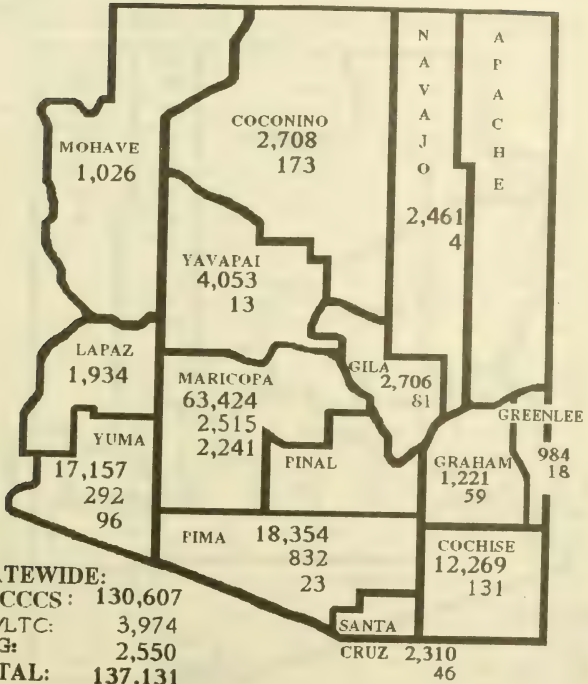
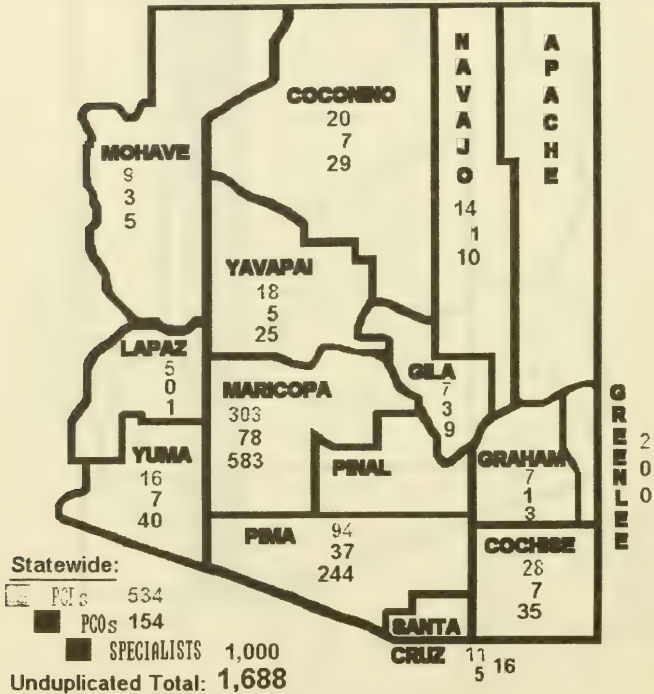


TABLE 7
ARIZONA PHYSICIANS IPA, INC.



PROVIDER NETWORK AS OF JULY 1, 1993



Chairman STARK. Mr. Harrington.

STATEMENT OF JAY HARRINGTON, PRESIDENT AND CHIEF EXECUTIVE OFFICER, NEIGHBORHOOD HEALTH PLAN, BOSTON, MASS.

Mr. HARRINGTON. Mr. Chairman, members of the subcommittees, I would like to begin my testimony by thanking you for the opportunity to appear here today to discuss issues related to the participation of Medicaid beneficiaries in managed care organizations.

Chairman STARK. If we let Congressman Neal here from Massachusetts, we have to let you, Mr. Harrington. It is only fair.

Mr. HARRINGTON. We are about to be in Springfield, Mr. Congressman, so—the Neighborhood Health Plan is a Massachusetts-based health maintenance organization with approximately 45,000 members. Of that total, about 75 percent are Medicaid beneficiaries. In my testimony today, I would like to discuss our experience in delivering the high-quality, accessible, and cost-effective health care services to that population. I will also discuss the problems that have arisen since Medicaid—the Medicaid program in Massachusetts secured waivers to implement a mandatory managed care program.

I would like to begin by giving some background information on the Neighborhood Health Plan. The plan was incorporated in 1986 by the community health centers in Massachusetts to serve the managed care needs of CHCs and their patients. It is organized as a 501(c)(3), not-for-profit organization. The board of directors of the NHP is elected by the CHCs in Massachusetts. It began operating in Boston in January of 1988 with six CHCs. Since that time, it has expanded to include all the community health centers in the State. We currently have approximately 60 primary care sites with 350 primary care providers. We have approximately 2,500 contracted specialists with over 50 hospitals in our service network. The hospitals in our network include all the major teaching hospitals in Boston, as well as many community hospitals throughout the State. In addition to enrolling Medicaid beneficiaries, the plan is offered as a health insurance option to the employees of over 150 businesses and governmental entities in Massachusetts. The plan has developed many unique and innovative programs. They include a program to provide health insurance coverage to small businesses as well as a program to provide managed care services to Medicaid beneficiaries in the latter stages of HIV infection.

The Neighborhood Health Plan believes that the most persuasive argument in favor of managed care Medicare for Medicaid clients is based in the issue of clinical quality. If a managed care organization is truly dedicated to structuring the environments of practice in a manner which enhances the quality and the scope of services, then managed care is particularly appropriate to the populations ill equipped to look out after themselves. The key lies in utilization of management function which is quality-focused and qualitatively driven, using clinical practice guidelines and other emerging tools to support clinicians and institutions in providing the best possible care at the lowest feasible price. That is, managed care is defined in terms of the clinical practice, rather than in the financial structure which supports that practice.

I think it is fair to point out that in a population with limited prior experience in primary and preventive care services, pent up demand and dysfunctional care-seeking behaviors may limit both quality improvements and cost reductions in the early years of managed care. That is, the fiscal switch from disease-care to health-care can be legislated in a single vote; but the behavioral changes expected of patients, clinicians, and institutions can only occur incrementally over time.

To bring some real life flavor to the issue of quality care for Medicaid beneficiaries enrolled in the Neighborhood Health Plan, I would like to present three case studies.

C.L., a 4-year-old boy, was hospitalized at a community hospital for the initial management of injuries sustained from a fall from an open window—of which there was an epidemic in Boston this past summer. He was transferred to a medical center hospital, which was 1.5 hours by public transportation from the family home, for orthopedic surgery, which was performed 4 days after the injury. The child's mother, a single parent with two other children, was able to visit only 2 to 3 days. On the ninth hospital day, the NHP utilization management nurse noted that the child no longer met the criteria for hospital level care. However, the attending orthopedic surgeon became very angry at the suggestion that the child should be discharged. Upon closer review by the NHP's medical director, it became clear that the key issue was the adequacy of physical therapy in the weeks following the surgery. By arranging twice-daily physical therapy visits at home, skilled nursing home visits twice weekly, and weekly paid transportation to the medical center for examinations, the surgeon was satisfied that the discharge was appropriate.

The child was reunited with his family 10 days after the original injury and had an uneventful recuperation with a net savings of \$12,000 to \$15,000.

The second case M.S., a 27-year-old mother with two small children, was hospitalized for a rapidly progressive liver failure resulting from viral hepatitis. Patients with liver disease of this severity rarely survive. The clinicians involved in the care of this patient considered liver transplantation to be the only hope for survival. The NHP transplant team, working with participating specialists and institutions in a nationwide organ transplant network, facilitated an emergency transfer to an appropriate center where transplantation occurred within 72 hours. After a difficult early post-operative course, the patient appears to be improving steadily.

The organizing structure of the NHP facilitated a rapid, high-tech response to a life-threatening situation. Both quality and cost for such a heroic, highly specialized care can be managed, to some degree, through cooperative network arrangements for services. In addition—and I think this is important to note—epidemiological data suggest that Medicaid populations have limited access to such services in a fee-for-service environment.

In fact, transplant rates for these populations are significantly below what their national averages are.

Case 3, J.R., a 10-year old child of non-English speaking parents with life-long asthma has been hospitalized repeatedly for respiratory distress. The clinicians caring for the family believed that

the compliance with drug therapy was poor and the child missed many clinic appointments. The child came to the attention of the NHP through a quality assurance study which sought to identify asthmatics at risk for repeated hospitalization. And we do that by looking at claims data as well as data from our pharmacy vendors. Linguistically appropriate member services and provider support intervention was implemented with prompt improvement in the medication use and the attendance at clinic appointments. A consulting asthma specialist visiting the health center under the auspices of the NHP examined the child and the allergy testing identified a dust-mite allergy. Hypo-allergenic bed sheets and plastic mattress covers were provided by the NHP, and there has been a dramatic decline in ER use and the frequency of hospitalization. Quality of life for the patient and his family has been improved, and the cost of care has been controlled through the use of a proactive, interventionist, quality-focused utilization management program.

Our quality efforts at the NHP are based on our definition of managed care, which is: A comprehensive, goal-oriented system for the provision of health care services in which respect, energy, and resources are invested in an ongoing relationships between the patient and the primary care clinician.

In terms of access, the Neighborhood Health Plan's goal is that it shall implement and maintain a system to evaluate waiting times for symptomatic and nonsymptomatic office visits and shall attain adherence to the Department of Health specifications.

The plan measures member access to medical services through a Member Access Survey, which is done on an annual basis. It is mailed out to all our members and followed up with a telephone interview.

The plan has found that, in fact, over 84 percent of our members waited less than 1 month for a checkup, and 67 percent waited 3 days or less for a nonurgent medical visits.

Mr. HARRINGTON. Over 80 percent of nonurgent medical visits were seen within a week and 87 percent of urgent medical visits were seen within 3 days, and there is a graph that details that. What we also note is that, overall, 73 percent of the respondents waited less than 30 minutes in the health center waiting room and 39 percent waited less than 15 minutes.

As past surveys have shown, satisfaction with care decreases as time spent in the waiting room lengthens. Of the respondents who waited less than half an hour, 74 percent were satisfied with the care they received during the visit. In contrast, 16 percent of those who waited 30 minutes to 1 hour and 9 percent who waited more than an hour said that they were satisfied.

The plan also considers the issue of access to the member's language at the health center to be an integral part of the member's ability to adequately access care. Data from all of our surveys show that 90 percent of the members were able to speak to someone at the health center who spoke their language. This data is consistent with previous member satisfaction surveys.

The plan also considers the ease of transportation to the health centers to be an integral part of the access issue and included a measurement in the member access survey. The data shows that

34 percent of the members walked to the health center and 40 percent drove to the health center and 22 percent used public transportation. In addition, 80 percent of the respondents indicated that they live within a half hour's travel time of the health center.

The last issue that I wanted to address quite briefly is the issue of cost. The question is: Does managed care save money for the Medicaid programs? And the first point that I would like to make is that, from the NHP's perspective, that is not a very important issue, that we are not in this business in fact to save money. We are in this business to provide quality, comprehensive services to the populations that are a part of our membership.

In my testimony, the written testimony, there is a long actuarial analysis that in fact tries to address this issue, and the first question is: Is there adverse selection in the Neighborhood Health Plan? And the data that we have indicates that that in fact is not a prevalent problem, and that is that when we compare our utilization and our enrollment to the State's fee-for-service system, we do not find that either people who are well are using the plan or that we are being adversely selected against. What we do find is that there are changes in utilization patterns and that we have been able to reduce hospital utilization as well as emergency room utilization.

In closing, what I would like to address is the history that we have had since the Massachusetts Medicaid program got waivers to implement a managed care program. The State of Massachusetts sought and was granted waivers from the Health Care Financing Agency to implement a mandatory managed care for Medicaid recipients.

Under the terms of the waiver, recipients who did not willingly choose to enroll in an HMO were assigned to a State-administered case management program. Due to poor educational efforts by the State, approximately 70 percent of the Medicaid beneficiaries were assigned to the case management program. When the assignment takes place, the recipient is told where they will be allowed to receive care and are, in effect, denied their right to select their own physician.

Since the assignment process has been completed, many serious problems have emerged. In applying for the waivers, the State assured HCFA that the recipients who were assigned to the case management program would have the right to disenroll from the program at any time if they wished to enroll in an HMO. The State has denied Medicaid beneficiaries this right by creating a complex bureaucratic process that makes it impossible or nearly impossible to disenroll from the case management program.

Other problems with access and the disruption of health care patterns have also emerged. As a consequence of these problems, the Neighborhood Health Plan is totally opposed to waivers which deny Medicaid beneficiaries their right to select their own providers. Waivers, if they are granted, should force the States to take whatever time is necessary to ensure that Medicaid recipients have the opportunity to select their own health care providers.

In essence, our feeling is that we should not deny Medicaid beneficiaries the right to select their own providers until we are in a position or willing to deny that right to all Americans.

Thank you very much.

Mr. McDERMOTT. Thank you.

[The prepared statement and attachments follow:]

TESTIMONY OF JAY HARRINGTON NEIGHBORHOOD HEALTH PLAN, BOSTON, MASS.

Mr. Chairman and members of the subcommittee I would like to begin my testimony by thanking you for the opportunity to appear here today to discuss issues related to the participation of Medicaid beneficiaries in managed care organizations. I am Jay Harrington, President and Chief Executive Officer of the Neighborhood Health Plan. The NHP is a Massachusetts based Health Maintenance Organization with approximately 45,000 members. Of that total about 75% are Medicaid beneficiaries. In my testimony today I would like to discuss our experience in delivering high quality, accessible, and cost effective health care services to that population. I will also discuss the problems that have arisen since the Medicaid program in Massachusetts secured waivers to implement a mandatory managed care program.

I would like to begin by giving some background information on the NHP. The Plan was incorporated in 1986 by the community health centers in Massachusetts to serve the managed care needs of the CHCs and their patients. It is organized as a 501-c4 not for profit organization. The Board of Directors of the NHP is elected by the CHC's in Massachusetts. It began operating in Boston in January of 1988 with six CHCs. Since that time it has expanded to include all of the CHCs in the state. We currently have over sixty primary care sites with 350 primary care providers. We have approximately 2,500 contracted specialists and over fifty hospitals in our service delivery network. The hospitals in our network include all the major teaching hospitals in Boston as well as many community hospitals throughout the state. In addition to enrolling Medicaid beneficiaries, the Plan is offered as a health insurance option to the employees of over 150 businesses and governmental entities in Massachusetts. The Plan has developed many unique and innovative programs. They include a program to provide health insurance coverage to small businesses as well as a program to provide managed care services to Medicaid beneficiaries in the latter stages of HIV infection.

QUALITY

The Neighborhood Health Plan believes that the most persuasive argument in favor of managed care for Medicaid clients is based in the issue of clinical quality. If a managed care organization is truly dedicated to structuring the environment of practice in a manner which enhances the quality and scope of services, then managed care is particularly appropriate to the care of populations ill equipped to look out for themselves. The key lies in a utilization management function which is quality-focused and quantitatively driven, using clinical practice guidelines and other emerging tools to support clinicians and institutions in providing "the best possible care at the lowest feasible price". That is, managed care is defined in terms of the clinical practice, rather than in the financial structure which supports the practice.

I think it is fair to point out that in a population with limited prior experience in primary and preventive care services, "pent up demand" and dysfunctional care-seeking behaviors may limit both quality improvements and cost reductions in the early years of managed care. That is, the fiscal switch from disease-care to health-care can be legislated in a single vote, but the behavioral changes expected of patients, clinicians and institutions can only occur incrementally, over time.

To bring some real life flavor to the issue of quality of care for Medicaid beneficiaries enrolled in the NHP I would like to present three "case studies".

CASE 1

C.L., a 4 yr. old boy was hospitalized at a community hospital for initial management of injuries sustained in a fall from an open window. He was transferred to a medical center hospital (1.5 hours by public transportation, from the family home) for orthopedic surgery, which was performed 4 days after the injury. The child's mother, a single parent with 2 other children was able to visit only every 2 to 3 days. On the 9th hospital day, the NHP utilization management nurse noted that the child no longer met the criteria for hospital level care. However, the attending orthopedic surgeon became very angry at the suggestion that the child should be discharged. Upon closer review, by the NHP's Medical Director, it became clear that the key issue was the adequacy of physical therapy in the weeks following surgery. By arranging twice-daily physical therapy at home, skilled nursing home visits twice weekly, and weekly paid transportation to the medical center for examinations, the surgeon was satisfied that the discharge was appropriate.

The child was reunited with his family 10 days after the original injury and had a uneventful recuperation, with a net savings of \$12,000 - \$15,000.

CASE 2

M.S. a 27 yr. mother with to small children, was hospitalized for a rapidly progressive liver failure resulting from viral hepatitis. Patients with liver disease of this severity, rarely survive. The clinicians involved in the care of this patient considered liver transplantation to be the only hope for survival. The NHP transplant team, working with participating specialists and institutions in a nationwide organ transplant network, facilitated an emergency transfer to an appropriate center, where transplantation occurred within 72 hours. After a difficult early post-operative course, the patient appears to be improving steadily.

The organizing structure of the NHP facilitated a rapid, "high tech" response to a life-threatening situation. Both quality and cost for such a heroic, highly specialized care can be managed, to some degree, though cooperative network arrangements for services. In addition epidemiological data suggest that Medicaid populations have limited access to such services in a fee-for-service environment.

CASE 3

J.R., a 10 yr. old child of non-English speaking parents, with life-long asthma, has been hospitalized repeatedly for respiratory distress. The clinicians caring for the family believed that compliance with drug therapy was poor, and the child missed many clinic appointments. The child came to the attention of the NHP through a Quality Assurance study which sought to identify asthmatics at risk for repeated hospitalization (by combining transactional claims data and clinical pharmacy data. A linguistically appropriate member services and provider support intervention was implemented, with prompt improvement in medication use and attendance at clinic appointments. A consulting asthma specialist, visiting the health center under the auspices of the NHP, examined the child, and allergy testing identified a dust-mite allergy. Hypo-allergenic bed sheets and a plastic mattress cover were provided by the NHP, and there has been a dramatic decline in ER use and frequency of hospitalization. Quality of life for the patient and family have been improved, and the cost of care has been controlled, through the use of a proactive, interventionist, quality-focused utilization management program.

Our quality efforts at the NHP are based on our definition of managed care which is:

"A comprehensive, goal-oriented system for the provision of health care services in which respect, energy, and resources are invested in an ongoing relationship between the patient and a primary care clinician"

ACCESS

GOAL: NHP shall implement and maintain a system to evaluate waiting times for symptomatic and non-symptomatic office visits and shall attain adherence to Department specifications.

The Plan measures member access to medical services through the Member Access Survey. This survey is an exit survey which is administered bi-annually to a statistically representative sample of health center members. The survey focuses on issues relating to health care access: appointment availability by type of visit, waiting time by medical visit, convenience of health center location, availability of a member's far, the Member Access Survey has been administered twice: first for members who had services during the first half of 1992 and again for members who had services during the first quarter of 1993.

Survey Methodology

The survey is administered to subscribers with family members who utilized health center services within the survey time period. The 1992 Member Access Survey was mailed to all subscribers who met the survey criteria. However, due to the uneven response rate by health center, the Member Access Survey was scored overall by Plan. As a result of the Plan's experience with the first Member Access Survey, the surveying technique was changed to a telephone survey. The second survey achieved a statistical valid random sample by health center which allowed the Plan to analyze access issues by primary care site. Consequently, all results reported in this goal relate to the 1993 Member Access Survey.

Survey Results

The Plan defines prompt access to care as two weeks for non-symptomatic visits, two to three working days for symptomatic visits and same day for urgent and emergency care. In the survey, the Plan distinguished the visit type into four categories: check-up or well child visit, a non-urgent medical problem, urgent care and life-threatening emergency. A check-up or well child visit corresponds with the Medicaid category, non-symptomatic visit, and a non-urgent visit corresponds to the Medicaid category symptomatic visit. The categorization of office visits is based on a member's self-reported reason(s) for the health center visit. Approximately 60 percent of visits were for check-ups or well child visits, 25 percent for a non-urgent medical problem, and 13 percent were for an urgent medical problem.

An analysis is by type of visit reveals overall for the Plan:

Visit Type	Waiting Time: Same day	Waiting Time: 1-3 days	Waiting Time: 4-7 days	Waiting Time: 8-14 days	Waiting Time: 15-30 days	Waiting Time: 1-2 mths	Waiting Time: >2 mths
Check-Up or Well Child Visit (Non-Symptomatic)	15%	19%	19%	10%	21%	11%	5%
Non-Urgent Visit (Symptomatic)	47%	20%	13%	4%	9%	5%	1%
Urgent Visit	76%	11%	3%	1%	6%	1%	0%

Overall, 84 percent of members waited less than one month for an appointment for check-up or well child visit, and 67 percent waited 3 days or less for a non-urgent medical visit. For urgent medical problems, 76 percent of members were seen on the same day. Moreover, 80 percent of non-urgent medical visits were seen within a week, and 87 percent of urgent medical visits were seen within three days. A graph showing waiting time for an appointment versus visit type is contained in Attachment 1.

In addition to measuring the appointment scheduling process, the Plan also examined waiting times once a member has arrived at the health center. Overall, 73 percent of respondents waited less than 30 minutes in the health center waiting room, and 39 percent waited less than 15 minutes. As past surveys have shown, satisfaction with care decreases as time spent in the waiting room lengthens. Of the respondents who waited a half hour or less, 74 percent were satisfied with the care they received during the visit. In contrast, 16 percent of those who waited 30 minutes to one hour and 9 percent who waited more than an hour said that they were satisfied.

The Plan also considers the issue of access to the member's language at the health center integral to the member's ability to adequately access care. Data from both surveys show that 90 percent of the members were able to speak to someone at the health center who spoke their language (Attachment 2). This data is consistent with past Member Satisfaction survey results.

The Plan also considers the ease of transportation to the health centers to be an integral part of the access issue and included a measurement in the Member Access Survey. The survey data show that 34 percent of the members walked to the health center, 40 percent drove to the health center and 22 percent used public transportation (Attachment 3). In addition 80 percent of the respondents indicated that they live within a half hour travel time of the health center.

COST

As a consequence of these problems the NHP is totally opposed to waivers which deny Medicaid beneficiaries their right to select their own providers. Waivers, if they are granted should force the states to take what ever time is necessary to insure that Medicaid recipients have to opportunity to select their own health care providers.

While managed health care continues to grow and evolve, questions regarding its cost effectiveness continue to arise. The reasons for these questions are primarily due to the multiple choice environment under which most managed health care plans operate. This environment creates three major dynamics that must be analyzed to prove cost effectiveness -- benefit differentials, selection criteria and health status. The first two can be accomplished using standard actuarial theory whereas the actuarial literature concerning health status and appropriate risk adjusters is just in its infancy. Other areas limiting potential cost savings of managed care programs that need to be examined are increased administrative costs, the price of managing the care, and shadow pricing, a practice of charging what the market will bear as opposed to the costs of providing care. These phenomena occur mainly in the commercial marketplace and to a lesser degree in Medicare and Medicaid programs.

We will concentrate our discussion of the dynamics Neighborhood Health Plan (NHP) experiences in the Massachusetts Medicaid marketplace. Although the Medicaid program now allows all categories of Medicaid eligibility, except for the aged, to enroll in its HMO program, we will concentrate only on NHP's AFDC enrollment. Because this population is categorically eligible, it enables us to look at an almost pure homogenous risk bad. Only instability of eligibility maintenance (involuntary disenrollment because of categorical eligibility loss) create possible bias in the group's risk structure.

Additionally, and most importantly, is the State rate setting mechanism. The State under HCFA regulations is not allowed to pay a plan more than the "upper payment limit (UPL)" that is defined as the fee-for-service (FFS) costs of an actuarially equivalent population. This methodology accounts for differences in benefit and risk structures by adjusting for demographics and non-covered benefits. All covered benefits are prescribed by the State. In addition, the State includes an allowance for administration based upon what is pays to administer its program for these members. This amount is usually in the 2-6% of premium range, much less than what it costs an HMO and specifically NHP to manage its program. In a voluntary program such as Massachusetts, it is imperative to market your HMO for selection by potential plan participants, a cost that is not borne by the state. NHP's marketing costs adds approximately 1% to its premium. Furthermore, to assure cost savings a State will typically set a savings goal. These savings were historically set about 5% of its FFS costs, although recently many states have been achieving savings as high as 20%. Furthermore, it is worthy to note the UPL is based upon the State's reimbursement schemes that are lower than those of commercial payors. According to a study entitled "State-Level Data Book on Health Care Access and Financing" performed by the Urban Institute, a nonprofit policy research and educational organization in Washington, D.C., Massachusetts professional fees represent 70% of those of private fee levels in 1990 which we project to be 65% currently. Additionally hospital costs are approximately 85% to 90% of commercial payor levels. Therefore, given these reimbursement realities and assuming no favorable selection, the only way for a program to be successful is to manage and coordinate its care better than the fragmented FFS environment. NHP showed approximately 2% profit on this line of business, although they paid their network providers more than the State paid, indicating Plan costs and utilization controls were working.

The first step in analyzing a program is to compare who is covered under the different environments, the FFS' and NHP's. During work sessions with the Massachusetts Medicaid Department, we were able to compare actual 1992 NP enrollment to the remaining fee-for-service population. Using age/sex factors supplied by the State, we determined that we had a favorable selection, albeit slightly, implying that NHP's expected cost should be 4% less than Massachusetts' FFS experience. We attribute this to the voluntary nature of the program. We do not intuitively believe we are attracting favorable health status enrollees because of the location of our sites (a network of urban community health centers) and that we offer an additional life insurance benefit that if considered during the selection process may actually adversely select against NHP.

This favorable enrollment is offset because the State did not estimate completed claims data. Because claims are adjudicated over time, it usually takes up to 18 months for all claims occurred in a particular service month to be ultimately settled. The State's actuaries, William M. Mercer, estimated IBNR (incurred but not reported) claims to be 4% of the total claims (pharmacy included) implying the UPL was understated by this amount. Therefore, NHP's expected claims should be only 0.1% less than the State's experience.

As with most managed care programs, the most cost effective reduction is the effective management of inpatient hospital resources. According to the study entitled "The Medicare Risk Program for HMOs - The Final Summary Report on Findings from the Evaluation (February, 1993)" prepared by Mathematica Policy Research, Inc., HMOs were effectively able to reduce average inpatient hospital lengths of stay by 17%, although the admission rate stayed approximately the same. NHP has almost experienced the same phenomena according to information supplied by the State as part of its UPL work groups with participating HMOs. NHP was able to reduce 1991 inpatient hospital utilization by 75 days, 10.4% and reduce 1992 inpatient utilization by 60 days, 9.3%. during this two-year period, admissions followed the same pattern of reduction that the State was experiencing. Although data is not currently available, we expect 1993 to exhibit similar trends because of our emphasis and availability of outpatient services for mental health and substance abuse services and managed by an outside contracted vendor.

Similarly for this same time period we also were able to reduce outpatient emergency room use by approximately 25%. Another area NHP has been able to extract savings from FFS environment is pharmacy coverage. Implementing a formulary approach and providing health centers with continuous clinical pharmaceutical evidence of available prescription options, NHP has been able to reduce pharmacy costs by 35%. It appears that although Medicaid receives large discounts on its more medically severe population, these discounts do not greatly impact AFDC costs. Even though comparable data is difficult to compare with the State FFS data, we believe that outpatient and physician services are greater than what the State is experiencing. This conforms to the new health care axiom "Care can not be created nor destroyed ... only practiced in more appropriate settings."

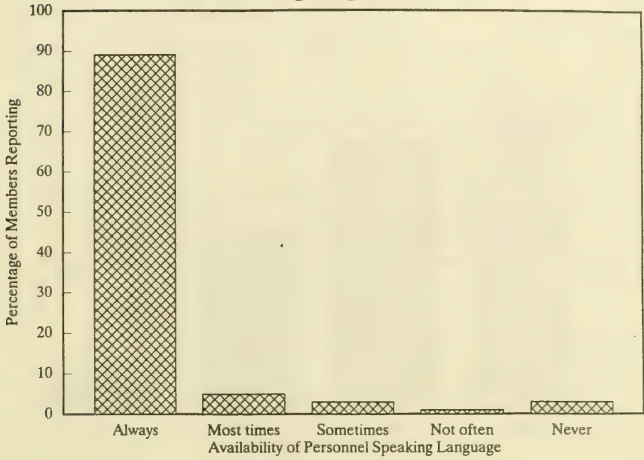
The last item to note is our reimbursement structure does include capitation. Because of the conservative levels we use for our capitations, under servicing the population is not a major issue. Our primary care capitation produces a significant increase over what our fee schedule would yield and actually mimics FQHC reimbursement thresholds. Our mental health capitation and pharmacy capitation programs have risk sharing elements, both positive and negative, to offer our vendors protection and proper incentives.

We believe NHP offers its enrollees the highest quality service at cost effective rates. We have performed client satisfaction and clinical measurement tests to monitor and improve our process. Our low voluntary disenrollment statistics support our beliefs. The issue does not seem to be whether the NHP saves the State money, but whether the State believes the savings to be sufficient relating to the risk the managed care programs bear. We at NHP believe that appropriate risk margins must be included to protect NHP and ultimately better serve our beneficiaries.

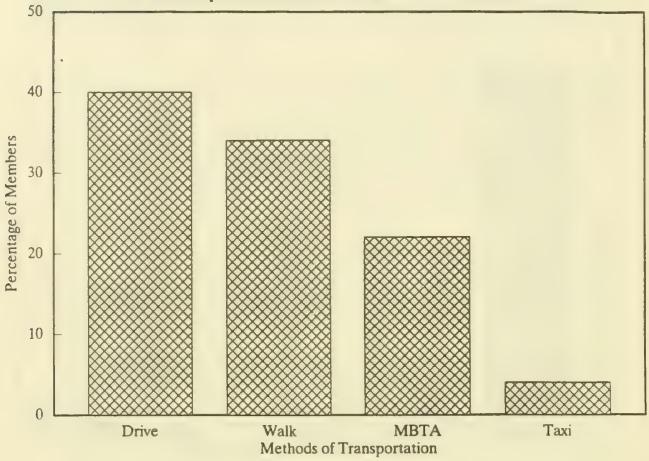
MANDATORY ENROLLMENT

The state of Massachusetts sought and was granted waivers from the Health Care Financing Agency to implement a mandatory managed care system for Medicaid recipients. Under the terms of the waiver recipients who did not willing choose to enroll in an HMO were assigned to a state administered case management program. Due to a poor educational effort by the state approximately 70% of Medicaid beneficiaries were assigned to the case management program. When the assignment takes place the recipient is told where they will be allowed to receive care and are in effect denied their right to select their own physician. Since the assignment process had been completed many serious problems have emerged. In applying for the waivers the state assured HCFA that recipients who were assigned to the case management program would have the right to disenroll from the program at any time if they wished to enroll in a HMO. The state has denied Medicaid beneficiaries this right by creating a complex bureaucratic process that makes it impossible to disenroll for the case management program. Other problems with access and disruption of health care delivery patterns have also emerged.

Access to Language at Health Center

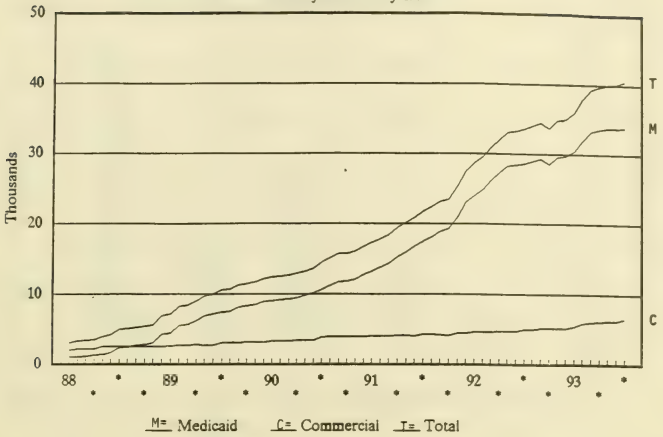


Transportation to Health Center



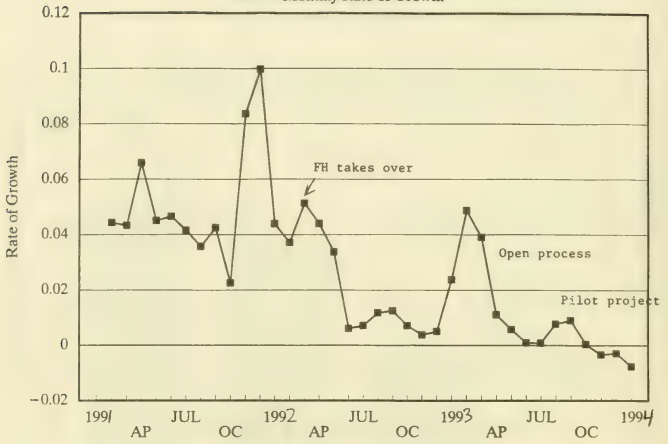
NHP ENROLLMENT

January 1988 – July 1993



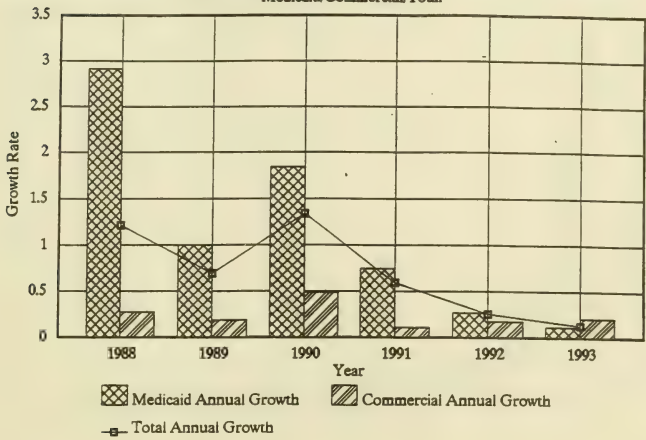
NHP Medicaid Enrollment

Monthly Rate of Growth



NHP Annual Membership Growth Rates

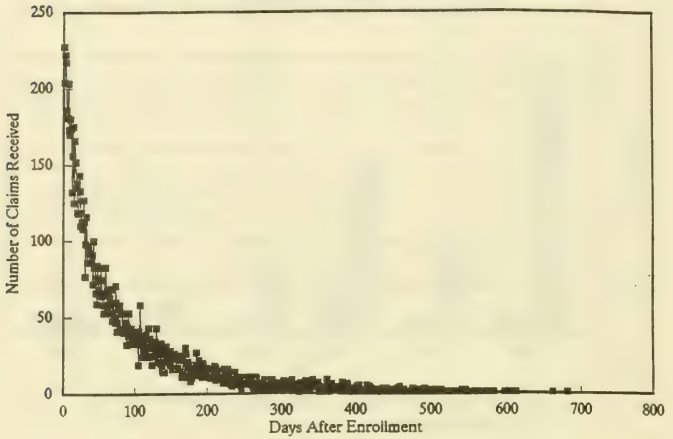
Medicaid/Commercial/Total



(1993 information is through July)

Time From Enrollment to First Date of Service

Based on New Enrollees after 1/1/90



Mr. McDERMOTT. Mr. Smith.

STATEMENT OF THOMAS P. SMITH, CHIEF OPERATING OFFICER, COMMUNITY HEALTH GROUP, CHULA VISTA, CALIF.

Mr. SMITH. Yes. Thank you for inviting me today to talk about all the good works that we are doing in San Diego County. I would like to begin my remarks by a kind of a colloquial description of our humble beginnings.

We started off over 20 years ago when a group of mothers in the hot desert sun were talking about, wouldn't it be great if we could get a doctor from San Diego to come down to this border town, San Ysidro, and see our kids once a week? Well, they were successful in getting the doctor to come down once a week and they got donated a little trailer that they put on the side of a cliff in San Ysidro. Later, that little trailer developed into a federally funded community health center with a 21-year history of delivering and increasing access of the Medicaid population in San Diego County.

We are primarily a minority-based organization that have honed the cultural competency and linguistic sensitivity over our history. 10 years ago, our federally qualified health center spawned an HMO that is now a full risk Knox-Keene health care service plan licensed under the California Department of Health Services and the California Department of Corporations.

We serve over 40,000 Medicaid lives, 16,000 of which are served by our own four primary care clinic sites. We employ 30 doctors through these sites and deliver primary care services to this Medicaid population. The nature of our network is very important to us. The nature of our network has a commitment to indigent care, health centers see patients whether they are members of our HMO or not, and they bill MediCal (or Medicaid in the State of California) on a fee-for-service basis.

Just like any other HMO, our primary care physicians serve as gatekeepers with our HMO nurses serving as case managers, case coordinators, and discharge planners. This we found to be a critical element in managing appropriately the care delivered to the Medicaid population.

The HMO serves as a hub of the case management activities. We have built in incentives for inpatient and emergency room utilization controls and hope to generate savings by delivering appropriate care and delivering those savings back into the network that serves our Medicaid population.

We pass on risks and rewards wherever feasible and financially possible. We include private physicians as well as community clinics in our network so that we are able to give our patients a broader choice and our health plan acceptance.

A couple of years ago, we were still having difficulty contracting with primary care and specialty physicians as well as hospitals. We had kind of a smattering of primary care and specialty physicians. Today, because of certain market dynamics in San Diego County, we now have over 1,400 physicians in our network.

Two years ago, we had six hospitals contracted with our health plan, and they weren't the best hospitals in San Diego. Today we have over 23, representing some of the finest institutions in the United States.

One of our principal goals is to increase access to our members, and we do this by maintaining access through an array of targeted community-based programs. We go out, we contact members, we have them come in, we schedule appointments, we keep track of all the immunizations that are required by the State of California.

Our direction is to develop and maintain the infrastructure of the traditional providers that have served the Medicaid population over the years. We hope to add a commercial line of business and a Medicare line of business, and through those lines of businesses, generate savings that we will then plow back into our network to increase access for primary care to our underserved Medicaid individuals.

The way we do this is we contract with quality providers, maintain uniform quality assurance and peer review programs, and support all cost-effective alternatives. There is one advantage to our plan in that we contract with community health centers. They have traditionally served the medically underserved. They are accustomed to providing a wide range of services because these patients lack resources and choices.

Community health centers are accustomed to making the most of health care dollars through benefit coordination and inhouse services. They are located in low-income communities where we have health care where you live. Transportation is typically a problem. We pay for transportation even though we are not reimbursed by the State of California for providing the transportation. We provide bus tokens, trolley tokens, and even pay cab fare into our primary care sites.

The market dynamics in San Diego County are truly remarkable. Hospitals, the occupancy rate of hospitals are exceptionally low. Hospitals and physicians are now clamoring to contract with us because they see Medicaid as a desirable line of business. Our specialty physicians are still greatly frustrated by the incredibly low per member per month premiums we receive from the Department of Health Services, I think some of the lowest in the country. We haven't had a rate increase in 4 years. Meanwhile, the hospitals negotiate with the California Medical Assistance Commission, receive a rate increase for their per diem rates on a yearly basis, and pass those increases on to the health plan; our health plan that is trying to serve this underserved community.

Providers are getting very sophisticated in San Diego County, and in fact in southern California, generally, capitation is really becoming the standard if not already normative. Physicians are getting quite sophisticated in terms of absolutely demanding to be capitated for primary care and specialty services.

Because the occupancy rates, in my view, are so low in San Diego County hospitals now are aggressively pursuing a per member per month payment capitation for inpatient services. Some of them have the ability and the infrastructure to deliver services on a capitated basis and others do not.

Our job is to ferret out those providers that have the sophistication to do that and to—we are currently designing programs, a risk sharing program that is fairly aggressive but aligns incentives like some of the other speakers talked about earlier so that only the ap-

propriate care is delivered at the appropriate time at the appropriate site.

One of the things we noticed in working with this population is that MediCal or Medicaid recipients use the emergency room as a primary care site. It is done out of force of habit. It is due largely to their not having access to primary care services.

One of the stories I would like to tell is—this is a true example—a mother took her child to the baseball game where he started off with a couple of pronto pups, caramel corn, hot dogs, Doritos, and then ate junk food all day long, got home, said, “I am very sick, mother, I have a tummy ache, please help me.”

The mother immediately took the kid to the emergency room. The doctor saw the kid, said, “Well, tell me what you ate today.” The kid told him. “You are suffering from junk food overload, what you need to do is go home, take some Pepto Bismol, and you will be better in the morning,” true example.

We paid a significantly higher rate to that hospital to treat in the emergency room when a bottle of Pepto Bismol would have taken care of it. What we decided to do is design an emergency room diversion, a nurse triage program which diverts inappropriate encounters in the emergency room like the one I just described to the appropriate site at the appropriate time, and this is all part of our increased access program.

If someone presents like that in the emergency room, the hospital will call us, tell us what the symptoms are, our nurse will triage. If it is appropriate to admit the patient, we give certification to the hospital to admit the patient. If it is not, and it is appropriate that that patient be seen in a primary care setting, we will arrange for the primary care visit the next day. It has had pretty dramatic effects already. We have had interest from all over the country about this emergency room diversion project.

I will conclude by just stating that we are very member oriented. There are significant benefits to our members who enroll in our plan as opposed to a fee-for-service methodology. Our members receive comprehensive coverage at no cost to our members. They receive quality of care from experienced, multilingual, culturally competent providers and staff.

We emphasize well child care and coordinate this with the California Department of Health Services guidelines. We emphasize preventive care through education, early diagnosis and treatment. We provide individual attention to meet personal health care needs because this population does, in fact, have different needs.

We provide after-hours services to assure continuity of care, free transportation via public transport system for the medically necessary services, convenient access through neighborhood community health centers and private providers located throughout the community, and we even provide services that have been mandated by the California Department of Health Services without a concomitant increase in our premium because we believe that those services are necessary for the health of our community, like lead testing, Hib vaccines, and Norplant insertions and removal.

Thank you very much. I would be happy to answer any questions.

[The prepared statement follows:]

**TESTIMONY OF THOMAS P. SMITH
COMMUNITY HEALTH GROUP**

Mr. Chairman and Members of the Subcommittee,

I am Thomas Smith, an attorney and Chief Operating Officer of Community Health Group, a non-profit health service plan that provides comprehensive health and medical care through San Ysidro Health Center, and a large network of contracted providers.

A. OVERVIEW

1. **SAN YSIDRO HEALTH CENTER:** A federally-funded health center with a 21 year history, and parent corporation to the HMO.
2. **COMMUNITY HEALTH GROUP:** A full-risk, Knox-Keene licensed pre-paid health plan for Medicaid beneficiaries. Regulated by the Department of Corporations and Department of Health Services.
3. **COMMUNITY PRIME CARE:** An out-patient risk Primary Care Case Management contractor to the California Dept. of Health Services.

B. NATURE OF NETWORK (refers to both clinic and private providers)

1. Commitment to indigent care; health centers see patients whether members or not, and bill Medi-Cal FFS if not members of Plan.
2. Primary Care physicians are gatekeepers, with nurses as case managers.
3. HMO at hub of case management activities.
4. Incentives for inpatient and EF controls (Savings Sharing).
5. Pass on risks and rewards whenever feasible and fiscally possible.
6. Include private physician community to provide patient choice, plan acceptance.

C. GOALS

1. **ACCESS:** Maintain access through array of targeted community-based programs.
2. **DIRECTION:** Develop infrastructure through capitated Medi-Cal network; include commercial employed uninsured population, Medicare, other public groups.
3. **METHOD:** Contract with quality providers only, maintain uniform quality assurance and peer review, support all cost-effective alternatives.

D. ADVANTAGES OF COMMUNITY HEALTH CENTERS

1. Accustomed to providing wide range of services because patients lack resources.
2. Accustomed to making the most of health care dollars through benefit coordination and in-house services.
3. Location in low-income communities "Health care where you live."
4. Dedicated providers don't discriminate; steadfastly provide all services necessary. (Control for over-utilization.)

E. ENVIRONMENT

1. **HOSPITALS:** Low level of uncompensated care; unfunded and Medi-Cal patients unevenly distributed.
2. **SPECIALTY PHYSICIANS:** Frustrated with Medi-Cal rates. Many don't take "new Medi-Cal" patients.
3. **PRIMARY CARE PHYSICIANS:** Experimenting with risk contracts; familiar with capitation concepts; sophistication developing rapidly.

F. NETWORK CONTRACTING OPTIONS

1. Community Health Centers--staff models, primary care contracts
Disadvantage: give away care, triage mentality, productivity.
2. Private Primary Care Centers--primary care contracts
Method: Request specialist names, cultivate office staff, provide fee-for-service equivalency reports.
3. Multi-specialty Groups--primary care, specialties and inpatient physician capitation.
Advantage: Claims Processing, Utilization Review and Quality Assurance.

G. PROBLEMS ENCOUNTERED:

1. Sole practitioner sites: administration costs, quality and peer review issues.
2. Multi-specialty Groups: financial solvency monitoring.
3. Addition of newly mandated services.
4. No fate increases but plenty of cost increases (impact of SB 48S).

H. SURPRISES

1. Community Health Centers used to audit/site inspections, win over auditors.
2. Easy to encourage 20% Medi-Cal to good groups.
3. Physicians are looking for entre into small group market.

I. PRIMARY CARE CONTRACT ELEMENTS

1. Capitation for primary physician services, x-ray, laboratory, and all outpatient pharmacy.
2. Fee-for-service billing for prior authorized specialty services.
3. Inpatient Emergency Room Savings Sharing -- Community Health Group shares portion with community based primary care subcontractors.

J. GROUP (IPA) CONTRACT ELEMENTS

1. Capped for inpatient physician services, outpatient x ray, and outpatient laboratory.
2. BR/Professional Services Risk Pool -- Community Health Group shares surplus in BR/Professional Pool based in utilization by PCP.
3. Stop-loss for capitated service risk.
4. Enrollment guarantee with offer of FFS reimbursement.
5. Pharmacy Control -- Limited to generic. Risk passed where possible.

K. HOSPITAL CONTRACT ELEMENTS

1. Negotiated per diem, exclusions as per State negotiated contract.
2. On-site Utilization Review.
3. Flat rate (or % of Medicaid) for ER visits.
4. Emergency Room physicians do initial triage and refer back to PC site for non-emergent cases.

L. INFLUENCING PHYSICIAN PRACTICE PATTERNS

1. Clearly define capitated services.
2. Require authorization for ambulatory care delivered outside of PC setting.
3. Encourage PC physicians to bill FFS for authorized specialty services.
4. Reward savings sharing to reinforce gatekeeping, ER diversion.
5. Provide Pharmaceutical in service training for cost-containment.
6. Include PC physician in "loop" of concurrent inpatient UR and discharge planning.
7. Authorize non-medical benefit if health and cost-effective.

M. ASSURING SUBCONTRACTOR SATISFACTION

1. Reimburse fee-for-service until enrollment minimum is met.
2. Conduct rapid enrollment to achieve critical mass.
3. Provide in-service training for case management and membership services.
4. Support physician efforts through strong patient management by the Plan.
5. Provide opportunities for collegial activities.
6. Encourage physician input to Plan policies and QA process.
7. Provide feedback on utilization and member satisfaction.

N. PSYCHIATRY INPATIENT SUPPORT SERVICES

1. **GOAL:** To provide quality comprehensive mental health care services by coordinating inpatient and outpatient services.
2. **OBJECTIVES:**
 - Continuity of mental health care
 - Inpatient case management
 - Psychiatric hospital discharge planning
 - Admission authorization process with admission criteria
 - Accessibility and coordination of services post hospitalization

O. RISK LIMITATIONS

1. State of California offers reinsurance option at \$25,000.
2. CHG subcontracts: Full physician risk contracts - \$8,500
primary care risk contracts - none

P. BENEFITS TO MEMBERS

1. Comprehensive Coverage - at no cost to members.
2. Quality Care - from experienced, multi lingual providers and staff.
3. Well Child Care - coordinated with Department of Health Service guidelines.
4. Preventive Health Care - through education, early diagnosis, and treatment.
5. Individual Attention - to meet personal health care needs.
6. After-Hours Services - to assure continuity of care.
7. Free Transportation - via public transit system for medically necessary services.
8. Convenient Access - through neighborhood facilities committed to the community.
9. Added Services - SB 485 feature

Q. NETWORK PHYSICIAN BENEFITS

1. Timely compensation direct from our local offices.
2. Local administration of Medi-Cal eligibility to by-pass State bureaucracy.
3. Free eligibility verification (800 and local #) no answering machines.
4. Specialty physician referrals are pre-authorized.
5. Authorization process may be initiated or extended by telephone or FAX.

R. CAPITATED PROVIDER BENEFITS

1. Patient management assistance.
2. Stable linkages to other health care providers.
3. Reduction in paperwork and staff time by eliminating Medi-Cal billing.
4. Assistance with preparations for State facility reviews and office staff training.
5. Quick inclusion of newborns as members for individual cap payments.

Mr. McDERMOTT. Thank you very much. Let me ask one question of Ms. Ignagni before I call on my colleagues. We had previous testimony from one of the witnesses about administrative costs in HMOs, and in managed care. Now, I know there are HMOs and then there are HMOs. So I am not unsophisticated about the various ways. But he testified that built in was 12 to 18 percent overhead plus he built in another 8 to 10 percent and said that 25 to 30 percent of the health care dollar went to administration before they ever got to the patients.

Now, how do we justify putting together a system where that kind of thing is possible, or what can we do about it, perhaps, is another way to put it? I don't think it is justifiable. I would like to hear your response to that.

Ms. IGNAGNI. First of all, Congressman, let me apologize, I wasn't able to be here earlier, so I did miss that testimony, so I can't comment on the specifics. Let me tell you, though, what I do know. I have never heard or seen data of the type and of the amounts that you have talked about.

We survey all of our members and also non-GHAA members: In other words, the whole industry every year. And our data indicate that the average administrative costs are running in the neighborhood of 6 to 9 percent, depending upon the plan, depending upon the part of the country, et cetera.

Of course, as you know, some of the smaller plans have higher administrative costs because they lack the economies of scale. Let me itemize some of the elements going into these so-called administrative costs for you, because we have been asking a number of our members quite a lot about this matter in an effort to provide more information.

Clinical practices and protocols: there is a great push within all types of HMOs now to use protocols to analyze practices, and part of the management information system cost for practice analysis goes into administrative cost. Quality assurance mechanisms are very, very vigorous and generate administrative costs. I think you are seeing more quality assurance mechanisms in the HMOs than the fee-for-service system.

There are also of mechanisms to detect fraud and abuse and patient grievance mechanisms. All of that is included in the pantheon of what we call administrative costs.

Now, I will be happy this afternoon—

Mr. McDERMOTT. All covered within the 6 to 9 percent?

Ms. IGNAGNI. It depends on the plan. There are ranges, as I said. I will be happy this afternoon to go back and pull out our data and submit to you a very detailed response in an effort to be even more specific than I have just been. There are a number of things that go into these kinds of costs.

Mr. McDERMOTT. If I could direct you to the testimony of Mr. Serfling of the California Pacific Medical Center, on page 4, he says that in HMOs in northern California, it is very common for providers to be charged between 12 and 18 percent of premium dollar for administration and overhead. In addition, we currently budget approximately 8 to 10 percent in additional costs.

Would you look at that and give us some reading on where that fits on the scale and why that might be true? It is a startling kind

of administrative burden for a managed care program to be putting in front of the committee as an advance in controlling costs.

Ms. IGNAGNI. Well, and I am sure that gentleman believes—and I do apologize for not hearing the testimony—believes the data that he had been given. We will go back. I find that rather perplexing, but I do believe in the maxim that never be afraid to say you don't know. So I simply don't have the information before me, but I will get back to you.

Mr. McDERMOTT. That is the best political answer there ever is. [The information follows:]

Based on 1992 data from GHAA's Annual HMO Industry Survey, a survey of 329 HMOs, mean administrative expenses as a percentage of total expenses for HMOs were 13.8 percent. Administrative costs in HMOs decrease with size of the HMO. Average administrative expenses as a percent of total expenses for 1992 were 17.2 percent for HMOs with fewer than 20,000 enrollees, and 10.7 percent for the largest HMOs, with more than 250,000 enrollees. These administrative costs include the costs of collecting data used to analyze clinical practices and quality assurance programs and malpractice expenses, as well as what is usually thought of as administrative expenses—the data needed to pay providers and keep the organization running.

This data appears to be consistent with Mr. Serfling's testimony in which he stated that he is charged between 12 and 18 percent for administrative costs. However, no reference is made to the range in administrative costs, that is, a relationship to the number of enrollees. Mr. Serfling also mentioned, however, that he budgets an additional 8 to 10 percent to cover "the infrastructure required to implement these agreements" with managed care organizations. This additional amount is presumably to comply with data reporting and monitoring requirements that are routinely included within the HMOs administrative costs. In order to contract with managed care organizations, it appears that Mr. Serfling's organization pays two types of administrative costs. The 8 to 10 percent administrative costs are paid to the managed care organizations to help them process California Pacific Medical Center's contracts. The Medical Center then spends additional money (the 8 to 10 percent) to collect the additional data that managed care organizations need as part of their quality assurance or financial systems. In other words, Mr. Serfling may be spending additional money to collect data that are included as part of the managed care organizations routine administrative costs. If California Pacific Medical Center collected these data routinely, this additional 8 to 10 percent would not be spent.

The issue that is raised here is the cost of merging incompatible systems, and the efficiencies of uniform and routine data collection. Mr. Serfling's situation points out the inefficiencies that occur when organizations that do not routinely collect specific data contract with organizations that require these data.

Mr. McDERMOTT. Yes, sir?

Dr. SCHALLER. Mr. McDermott, I will confirm what Karen said. We manage a 145,000 member Medicaid-only IPA in Arizona, and our administrative costs are just under 8 percent. The access administration takes a look at each health plan's bid during the bidding cycle, and they will reject any estimate of administrative costs over 12 percent.

Mr. McDERMOTT. Is that 8 percent at your level and then 12 percent down at the plan level?

Dr. SCHALLER. No. That is 8 percent at the plan level.

Mr. McDERMOTT. That is 8 percent totally? And then what is yours, on top of that 8 percent?

Dr. SCHALLER. No, the administrative costs are the State costs, and I am not sure what those are, but what I meant to say was that when a health plan bids, the access administration looks at the administrative costs and, generally speaking, the administrative costs near 12 percent are generally those of the smaller plans that have anywhere from 1,300 to 2,000, 3,000 members. Their

costs are a little higher than the larger plans, which can get their administrative costs down under 8 percent.

Mr. McDERMOTT. Thank you very much.

Mr. Thomas will inquire.

Mr. THOMAS. Thank you very much, Mr. Chairman.

Mr. Smith, your experience is one that I am familiar with in my area, and one of the concerns I have is in trying to provide quality health care in rural areas, especially when they are not often viewed every time an area of money goes up, you tend to be left out, but you have had a remarkable growth curve based upon your testimony.

The question that I would ask goes to the question of quality because, obviously, there have been a number of witnesses who have disparaged both managed care as a concept in terms of quality and specifically that it ought not to be applied to the Medicaid area.

Your goal is to principally serve Medicaid, MediCal patients. Do you have folk come in who are not Medicare, MediCal, and do you have any information about whether or not that population is growing in recent years?

Mr. SMITH. Through our community health center, we do see patients that are considered the indigent care patients, and the responsible payer is the County of San Diego. We have a contract with the County of San Diego to provide care for those indigent care patients. As you probably know, the State has promulgated a managed care program to transition fee-for-service MediCal patients.

Mr. THOMAS. I have 2 of the 13 counties that are going through the pilot program.

Mr. SMITH. Lucky you.

Mr. THOMAS. I believe lucky me in both Kern and Tulare Counties. Do you have people who would otherwise go to a regular doctor on a fee-for-service structure that actually utilize your facility?

Mr. SMITH. Mostly all the members that are members, all the individuals that are members of Community Health Group, our health plan, have to seek services within our network. There are exceptional incidences where we won't have the appropriate service contracted in the network and will arrange for that service to be delivered by a noncontracted provider, but in terms of your remark about quality in the rural area, we contract, for example, with Mountain Health Center which is out in the eastern portion of San Diego County, quite rural.

They are held to the same standards as someone like a Scripps Clinic or a Sharp Rease Steely Medical Group, a sophisticated large physician organization. Some of the community health centers are not as sophisticated as others because we have a 20-year history of dealing in managed care in the Medicaid population, we feel obligated, and we do provide training to these less sophisticated community clinics and are trying to bring them up to speed so that they can participate in what is happening.

Mr. THOMAS. Of course, with electronic and the technological revolution that has occurred, it is going to be a whole lot easier linking them up through various telecommunication structures.

Mr. Harrington, you also have given us a success story, not only one in terms of delivering service but in several of your case stud-

ies, a clear sensitivity to care of the patient and the savings of money at the same time which, in an anecdotal way, clearly offsets some of the anecdotal presentation from the chairman. But this is in Boston, Massachusetts, you know, and everybody believes Boston, Massachusetts is different than most other areas, at least those people outside of Boston.

Mr. HARRINGTON. They are right.

Mr. THOMAS. Are they so right that what you have done in Boston could not be done elsewhere?

Mr. HARRINGTON. Well, the first thing I would like to note is that while we started in Boston, we now cover the whole State of Massachusetts. I am originally from the south, and definitions of rural in the south are a lot different than they are in the north.

But I would suggest quite the contrary, that the experience that we have had in effectively managing care for Medicaid recipients can, in fact, be replicated, that we have demonstrated that you can incorporate large teaching hospitals, public hospitals, and community health centers, that serve inner city populations effectively into managed care programs as well as health centers that are outside metropolitan areas.

So I would suggest, in fact, we have—the State of Rhode Island applied for and received waivers to implement a mandatory Medicaid program for managed DD—managed care program for Medicaid recipients, and we have helped the health centers in Rhode Island organize themselves into a new HMO called Neighborhood Health Plan of Rhode Island which will represent the managed care interests of community health centers and other essential providers in that State also. We have had some discussions with the health centers in Connecticut also about facilitating their entry into managed care programs.

Mr. THOMAS. Briefly, Dr. Schaller, and you may want to have your structure in Arizona submit this in written form, but I am very interested in how you were able to invent a reimbursement system where you really didn't have a fee-for-service comparison.

Did you have a startup problem in terms of trying to get an accuracy on the prices? Was there an adjustment period? Are you continuing to adjust? Did you come up with a formula?

Dr. SCHALLER. Yes. Mr. Thomas, Arizona was the last State in the Nation to adopt a Medicaid program, and according to what I have heard, the legislators were fearful that if they did start a Medicaid program, the Indian Health Service might pull out and they would be left with all the Native Americans in the State.

They started the program, and what has happened is that has not been the case. So we, in effect, did not have any startup problems that involved the conversion from fee-for-service to prepaid care or capitated care. And as you can understand, that is a very important issue because it means, that there is a period of double payments that is a very serious obstacle for the States with a pre-existing fee for service Medicaid program, so we didn't have that problem.

The main problem we had was the failure of the regulatory process in the beginning so that some of the issues that caused the problems for the State and the health plans were quite serious, and it took some time to straighten all of those out.

Mr. THOMAS. Ms. Ignagni, we have seen some examples, especially the GAO study of some of the changing models in managed care.

Ms. IGNAGNI. It is certainly a moving target.

Mr. THOMAS. It is a moving target. The question I want to ask you is, from your perspective inside your organization, do you believe that you go to a first, a second, and a third generation restructuring, notwithstanding changes in law? Because, obviously, that would give you additional opportunities with antitrust changes and others.

Are we looking at currently pretty much the universe of different structures, or do you continue to see a lot of restructuring, and in what way can we facilitate restructuring through legislation or hinder it?

I guess that is a back door way of talking about the administration's proposal. Does it help, does it hurt in the ongoing evolution clearly of a slightly different method of delivering health care services?

Ms. IGNAGNI. I very much appreciate the question. Back in 1988, just to give you a benchmark relative to 1993, the average age of plans in the industry—now of course there are major exceptions, some of the larger plans that have been talked about quite a lot today, but the average age was 3 years. Now the average age is 7 years, so you are seeing a more mature industry.

Point number two, that as we look into the future, I think what we will be seeing—and it is a risky proposition, of course, predicting—but what we will be seeing is a lot of changes. Some of the traditional plans will begin to investigate point-of-service kinds of options, and some of the newer plans will toward capitation and some of the virtues and tenets of staff models. We see a lot of movement in various directions.

So I think anyone who wants to make some judgments about what is going to happen would be hard pressed, but I do think that what all of this boils down to is that plans are responding to demands in the marketplace made by consumers, and they are doing that in a variety of ways, depending upon their location, depending upon the population served, and depending upon a variety of factors which are very peculiar to the particular part of the country.

So I do think we are going to see that this will be a very dynamic industry. I think consumers are excited about that and also a confidence in that, and I think that they may very well be ahead of the health policy community in making decisions because HMOs are working for them.

I appreciate the question, and the reason I made the remark about the moving target was the testimony you heard from the General Accounting Office. I wasn't here to hear their testimony, but did see their written statement. Many of the studies that they reviewed were old. That is not a fault of the GAO.

Newer information simply does not yet exist to reflect both changes in the market today and the maturity of the industry. That is one of the things that we tried to do in contracting with Peat Marwick. We think one of the chief researchers there has one of the highest reputations in the health policy field. He looked into this question of whether there is a onetime savings or a long term

savings, what can we look at to shed some light on what has become a very vexing question.

But, Mr. Thomas, I want to make it very clear that we don't think that is the end of our responsibility. We think that what we need to do is go to other researchers, continue to pursue this, unpeel the onion, so to speak, so that we, on behalf of my colleagues that are sitting here and those that are not here today, our members, can provide adequate opportunity, adequate information to shed light on a question that I know all of you have struggled with.

Mr. McDERMOTT. Mrs. Johnson will inquire.

Mrs. JOHNSON. Thank you, Mr. Chairman.

Ms. Ignagni, would you pick up a copy of the GAO's summary testimony—not now at this minute, I just want to get this back in the record. I do want you at a later time to get back to us on specific things that they quoted, because the juxtaposition of the conclusions of these surveys and the context in which they quoted them raise a lot of questions.

And basically they are saying that their information shows that premiums in managed-care plans are not lower than premiums in indemnity plans, and there is just so much information that contradicts that. I find GAO putting its name on this kind of material very concerning.

For the rest of you, it is too bad GAO couldn't stay for the rest of this hearing, it is really a pity, because throughout it, the preceding panels and others, we have gotten a much better insight into actually how managed care controls costs, and the degree to which it has to be a system. It really has to be an integrated system with a commitment to both cost and quality, and that you don't get it in the first changes, you get it over time, and the kinds of surveys they are doing where they don't even distinguish between whether the premium this year, while it may be the same, includes more benefits or fewer is simply useless to us in policy-making, and a sad waste of taxpayers dollars, I might add.

So if you would look at their use of studies, Ms. Ignagni, and get back to us, what is the more recent information, that would be very helpful. And then perhaps we can get into some realistic dialog with GAO and get some better information. They themselves say that their information is all inconclusive, because it is apples to oranges. More to the point.

[The information follows:]

Mr. Nadel's testimony concerning GAO studies of HMOs raised the following points, which are addressed sequentially:

- Little empirical evidence exists that employers' overall health care costs have been constrained by using managed care plans.

The evidence indicates that premiums are lower in employer-sponsored HMO plans than in fee-for-service and indemnity plans (KMPG Peat Marwick, *Health Benefits in 1993*), and that they are growing at a slower rate in HMO plans. Between 1988 and 1993, monthly premiums in HMOs for individuals rose 10.1 percent, compared to 15.3 percent for FFS individual plans, and 13.9 percent for point-of-service (POS) individual plans. For family HMO plans, the rate of increase between 1988 and 1993 was 13.1 percent; for FFS and POS family plans the increases were 18.7 percent and 16.1 percent, respectively (KPMG Peat Marwick, 1993).

The Foster Higgins National Survey of Employer-Sponsored Health Plans, 1993, shows that for large employers, costs per employee in traditional indemnity plans rose 8 percent between 1992 and 1993, in PPOs the increase was 10.4 percent, in POS plans the rate was 8.9 percent, and in HMO plans the increase was 6.2 percent. For small employers, however, PPOs had the slowest rise in costs per employee (0.4 percent), HMOs employee cost rose 6.2 percent, and traditional indemnity cost per employee rose 6.3 percent between 1992 and 1993.

It is unlikely, however, that savings from managed care plans are not directly passed on to employers because employee cost-sharing or out-of-pocket expenses is reduced or benefit packages are expanded. Since 1988, employee cost-sharing has increased, although not dramatically. HMOs typically do not have deductibles or copayments. Deductibles for FFS plans have risen by 59 percent for individual coverage and 52 percent for family coverage since 1988 (Peat Marwick, 1993). A study by the MEDSTAT Group, using utilization and cost data from 80 large firms, concluded that PPOs often achieve savings to employers through cost-shifting to the employee rather than an overall reduction of costs through price and utilization controls (Foster Higgins, 1993). In addition, FFS plans have added more benefits to their packages since 1988 than have HMOs, primarily benefits already offered by HMOs in 1988, such as well-baby care and adult physicals (Peat Marwick).

Therefore, while it is difficult to conclude that HMOs save money overall to all employers, recent evidence exists that HMOs have lower premiums than FFS plans; their premiums grew at a slower rate since 1988, and PPO rates of increase in premiums are increasing the slowest of the three plan types in recent years (HMO, FFS and PPO).

- A major constraint on consumers of managed care is their more limited choice of physicians. Based on a review of one article, Mr. Nadel's testimony concluded that "overall, patients receiving care from prepaid providers rated their care lower than patients visiting fee-for-service providers". (Haya R. Rubin et al., "Patients' Ratings of Outpatient Visits in Different Practice Settings: Results from the Medical Outcomes Study, JAMA 270, 7 (1993), 835-840.

The most recent and representative data on this topic were collected by the National Research Data Corporation in 1994. They conducted a survey of 10,109 household respondents asked about satisfaction with health plans on a variety of dimensions. Overall, results were similar to the Rubin et. al study. HMO members were more satisfied, however, with their health plan overall than traditional FFS or PPO enrollees (23 vs 19 and 13 percent, respectively of respondents answered that they were "completely satisfied" with their plan). HMO enrollees were more satisfied with the amount they pay, and the length of time spent filling out claims. HMO members were about as satisfied as FFS and PPO enrollees with their overall medical care, the number of days it takes to get an appointment, the quality of care, and minutes waited in the office.

Data shows that HMO members are more satisfied with their care overall, and are as satisfied with their medical care overall and the quality of care they receive as are FFS or POS enrollees. The Rubin et al. article also indicates that HMO members are more satisfied with the affordability and coordination of care in their plans, and as satisfied overall with their hospital care, as FFS enrollees.

Ms. IGNAGNI. Could I make a comment on that, Mrs. Johnson, for the record?

Mrs. JOHNSON. Yes.

Ms. IGNAGNI. I do think, and we over the last couple of days have understood that the GAO has been talking to the researcher who did our report, and I think that that is very encouraging. To say one thing on behalf of the GAO, I think they did a survey of the literature. I know in talking with some of the GAO analysts that they are as frustrated as you are that the literature has not really kept pace with the change in the industry, as it hasn't in so many other areas.

Mrs. JOHNSON. I understand that, Ms. Ignagni, but the fact is that should have been up front in their study, that the literature is outdated, that the studies were done on narrow populations, mostly in the 1970s and some in the 1980s, and information is not transferable. They said that at the end, but it is not enough for public policy.

Ms. IGNAGNI. You will be excited about our research.

Mrs. JOHNSON. I want to work back on understanding the most recent information and the context of their information and talking with them about why they didn't use it or at least allude to it. That is all to the side. I am much more interested in the testimony the three of you have given, which really demonstrates the power of managed care to serve low-income populations and to partner—at least, Mr. Harrington, you indicate that you have also developed a small business product, and are able to serve the private sector as well.

Could you just enlarge on that a little bit. And just as an aside, since you are statewide, GAO could have looked at some of the very issues that they said they had a hard time looking at in terms of amount of benefits. It sounds to me from what you describe that there are people inside your network and outside your network both on Medicaid, so they could have looked at control groups.

In the detail of your testimony, you do talk about risk selection, whether you have a better population, and then the premium setting issue, so comment on just two things. First of all, what is the potential of the kinds of networks that each of you has developed to expand to the small businesses in the areas where you have resources and bring them in on the same terms, for example, that you are serving Medicaid? That is part of it, then have you had to develop differentiated premiums for the reimbursement of certain Medicaid populations versus other Medicaid populations?

This is a significant issue in Medicare, so if you could talk to those two things.

Mr. HARRINGTON. The small business insurance program was a program that we developed in cooperation with the State of Massachusetts, and in that program we, working with the State, were able to offer market rate premiums to small employers.

The State provided an aggregate reinsurance mechanism which mitigated against the adverse selection issue which allowed the product to be cost-effective. It is an issue for us because up to half of the patients who go to community health centers are uninsured, and they are uninsured because their employers tend to be small

employers who operate in the neighborhoods that the health centers serve.

We ran the program for 3 years or so and now have converted that population into our general commercial population, and what we found was that in fact when small businesses were offered premiums that were equitable to what we offered to large employers, then they in fact were able to purchase the product. We did not have any adverse selection at all in the sense that the population enrolled under that program looked like our commercial population.

The second program that I mentioned in my testimony is one that I want to highlight, and that is that we have a contract and a program with the State Medicaid program to enroll people who are HIV+. As far as I know, we are the only HMO in the country that goes out and solicits HIV+ folks to enroll. And the data on that case has also been very dramatic, that the HIV patients that we have enrolled in our case management program have very different care seeking patterns than the general HIV population. We have significantly reduced inpatient utilization as an example through the case management program.

My feeling is that, in fact, the Neighborhood Health Plan can be replicated. And one of the suggestions that I would like to offer is that in any legislation, I think it is important that essential community providers be encouraged to band together to form their own managed care organizations. My feeling is that they are different and that those differences will not be tolerated in the larger—if in fact the essential community providers are just smaller portions of a larger HMO.

Mrs. JOHNSON. That is a very constructive suggestion that we specifically address the issue of essential community providers banding together.

Dr. SCHALLER. The AHCCCS program also has a small group package. Three years ago, the AHCCCS administration began supporting what is known as a health care group. I might add that in the initial enabling legislation, the legislature and the Governor gave the AHCCCS program the right to grant the health plans within the AHCCCS program to go into commercial coverages, and because of the initial problems the program had, not much was done in the early years.

About 3 years ago it started. About a year ago, the Arizona Physicians IPA, our plan, got started underwriting small group coverage, and we now have 5,000 lives covered, and there is some underwriting, but the premiums are quite low and the benefit package is fairly broad.

One advantage that that group has is that we can charge or we can pay the hospitals that provide services to these 5,000 enrollees at the same rates that we pay for the Medicaid recipients. We also provide service to about 4,200 of the developmentally disabled population, and currently the plan is preparing a bid to enroll some of the school districts within Arizona, so they are making a very positive step to become involved in the commercial marketplace.

Mrs. JOHNSON. Excellent.

Mr. SMITH. Mrs. Johnson, we also are developing a small group commercial product and are targeting primarily minority small

group businesses, most notably the Latino population, the African-American population, and the burgeoning Southeast Asian population in central San Diego, and we believe that as the economy in California is bottomed-out now and starts to improve, individuals that we service now as MediCal beneficiaries will become employed and will simply follow them through to small employer groups, enhancing the continuity of care that we have been trying to achieve.

We hope to generate some savings through inpatient utilization and take those savings and plow that back into access for the medically underserved.

Mrs. JOHNSON. Thank you. It is impressive how far the private sector is ahead of the government in actually front-line development of comprehensive managed care, integrated systems of care that are very flexible, very locally oriented, very able to deal with many things. I was fascinated that some of you provide transportation. You really are able to meet the needs on the local level in a way that Medicaid and Medicare have never been able to be responsive.

I think that is a big message, that you are responsive in a way that even when Medicaid was reimbursing at accepted levels, it wasn't that responsive, it couldn't deal with transportation, and those things. So I really commend you on your leadership in each of the areas of the country that you work in and appreciate the quality of the testimony of this panel.

Thank you all.

Mr. McDERMOTT. Just for the record, I think it is important to note that a careful reading of the Peat Marwick study clearly shows that although the premiums in HMOs increase more slowly than fee-for-service plans, the benefits in fee-for-service plans have increased more than they have in HMOs, and I think that we can criticize the GAO, but this is a real difficult problem to figure out how to match apples and apples. There is an awful lot of use of figures, and I think we are going to go through an awful lot of that.

Mr. McCrery will inquire.

Mr. MCCRERY. Thank you, Mr. Chairman.

I will be glad to let Ms. Ignagni respond. She looked like she was willing to say something.

Ms. IGNAGNI. Thank you, sir.

I would be delighted to. I suppose, Congressman McDermott, you are referring to the increase in adult physicals, for example, in the fee-for-service area going from 20 to 43 percent, still relative to 93 percent in HMOs. There was a gain, but I think we would all agree that there is still much to be done. That was the one area that was singled out as a benefit improvement.

I think, as you know, this committee has really thought long and hard about the issue of how much consumers are actually paying out of pocket. We need to look at the total picture. One of the things that I think is very impressive and valuable from a consumer standpoint is that there are no deductibles in HMOs whereas, you know, in the fee-for-service sector, over 1988 to 1993, the deductibles have increased 59 percent, far outpacing wages and other kinds of exogenous measures that we might use.

I think what you want to do is look at the whole package. The Peat Marwick study is the beginning of contributing to a newer

body of data that do reflect the dramatic changes that have been going on in the industry. We want to try to get our hands around the value of wellness and prevention, the value of some of the social services that my colleagues have talked to, the value of long-term management.

We know anecdotally from Berkeley and Rand, which have just done studies recently, that young pregnancies and high risk pregnancies are being managed much more effectively in HMOs than in fee-for-service. The New England Journal of Medicine recently showed that HMOs more effectively manage coronary care episodes than fee-for-service. This really gets to the heart of the comprehensive coordinated care about which my colleagues have testified.

I witness front-line testimony today, but I quite agree with you, and we would be the first to say, we want to be in a leadership role of trying to do more, trying to get our hands around this and peeling that onion so we can be helpful to you in giving you the facts.

Mr. MCCRERY. I was right, Mr. Chairman, she did want to respond.

Mr. MCDERMOTT. I knew I had provoked her, but I wasn't going to give her a shot, but you were kind to her.

Ms. IGNAGNI. I am terribly pedantic, what can I say?

Mr. MCDERMOTT. That is your old Labor background.

Mr. MCCRERY. Mr. Smith, how is your group paid? Are you paid on a per capita basis?

Mr. SMITH. We have a contract with the California Department of Health Services and are paid according to aid category on a per member, per month basis. The average rate for all aid categories is about \$85. The majority of our patients are AFDC, and the rate for AFDC is \$72 and about 10 cents, I believe.

Mr. MCCRERY. And, basically, the reimbursement that the State of California gives you is derived from Federal Medicaid funds and State matching funds?

Mr. SMITH. The way the capitation rates were developed is we believe on a faulty comparison to a fee-for-service MediCal population basis. Currently, there is an actuarial study being conducted right now to take a look at the rates again, but it is based on a fee-for-service equivalency.

Mr. MCCRERY. But the funds come from Federal Medicaid funds and State matching funds?

Mr. SMITH. The funds come from the State of California, and then I guess through—yes, right, Feds to the State.

Mr. MCCRERY. OK. I assume, Dr. Schaller, in Arizona, that that was the case, that your operating funds when you were with the State Medicaid system came from the Federal Medicaid funds and State matching funds?

Dr. SCHALLER. Yes. The funding came from three sources. We have a category of covered lives called the medically indigent and medically needy, and there was no Federal funding for that category of population, so that funding came from the State and the counties.

The county's contribution was fixed at 50 percent of what they budgeted or spent for indigent care in fiscal 1980, 1981. Then, additionally, there is a Federal financial participation which at time

was about 62.5 percent of the costs, and then the State made up the difference through an appropriation from the general fund. So the funding was from those three basic sources for the whole program.

Each health plan that bids must bid by county and by each of the 11 categories or cells of covered lives, and any bidder must bid all the categories. The State did not want any health plan to cherry pick a certain population like AFDC or another population they thought that maybe they could find more profitable, so every plan covers every category of eligibles, and every Medicaid recipient in the State is mandated to be covered by one of the 14 health plans that currently contract for service.

There are some tables in the paper that I gave that list all of the 14 health plans. It shows the size, and basically six of them are rural plans, three of the plans are larger and provide services to both urban and rural market, and then the remainder provides services mostly to just urban folks.

Mr. McCRERY. OK. If we here in Washington were to decide that the Medicaid delivery system should be a managed care system in every State, would the Arizona example transfer to all other States? And I know you don't have a knowledge of every other State, but based on what you know, would you think it could be done?

Dr. SCHALLER. Yes, I think it could. Recall, though, that the one serious problem is that, if a State has a preexisting fee-for-service Medicaid program, there is a tail of claims that will extend out for perhaps 18 months, that is, it will take 18 months to get all the bills in, and all the moneys paid.

Then, if you overlay that or replace that with a capitated system that requires payment up front for each of those 18 months, there is going to be a double payment in the beginning that will gradually decrease over the 18 months of the double payment, and that is a serious obstacle. The States that have had to address this problem have generally tried to piecemeal it and enter the Medicaid, the prepaid Medicaid or managed care Medicaid arena piecemeal by a few counties at a time. Wisconsin tried that. They did it in Milwaukee, and the county around Madison. Other States have tried to face up to that, too, but I believe that the managed care system could be transposable.

One of the important aspects that must be addressed is that of the ability and the skills of the regulatory process. As I stated in my paper, I felt that the problems of the early prepaid plans in California with HMO International, the problems with IMC in Florida, and the early problems we had in Arizona were substantially contributed to by the failure of the regulators to understand that they are not just Health Department folks or Insurance Department folks looking at policies, they must learn how to regulate this very competitive business in which there is all kinds of room for abuses. A health plan can play games with the incurred but not reported claims (IBNR).

We found in Arizona, for example, that in order for us as the regulators to really understand what was going on with some of the health plans, we had to demand that each plan produce for us a monthly claims aging statement because, as claims got older or it

took longer to pay them, you could sense that there was a cash flow problem within the plan.

We also asked for a monthly cash flow analysis. We asked for a quarterly financial statement, and an annual audited statement. The traditional State Insurance Department approach of requesting an audited annual financial statement isn't good enough because that usually doesn't occur until 6 months after the end of the fiscal year, and a health plan can get in a lot of trouble in less than 6 months.

And so if you have a new group of plans and if you have an inadequate or a poorly trained regulatory staff, the regulators must learn to be on the front of the curve and sense when the health plans are having trouble before the health plan knows it themselves.

Mr. MCCRERY. Just briefly, Mr. Chairman. What was your experience in Arizona after converting to a managed care plan for your Medicaid population in terms of cost and ability to broaden the universe of people served?

Dr. SCHALLER. The experience has been very good. Our estimates are that the costs on a per capita basis are something around 14 to 16 percent less than a traditional fee-for-service Medicaid program. We found that we were truly able to mainstream the health care of the patients in the Medicaid program.

Eighty-five percent of the licensed physicians in the State of Arizona are registered providers in the access program today. The patient satisfaction in 1985, 1986—and I am not familiar with the details of the years since 1987—but the patient satisfaction was in excess of 95 percent, that the dissatisfied persons with the program as far as the patients were concerned were less than 3 percent, so the patient satisfaction was good.

We were able to conduct statewide statistically valid medical audits in which in the beginning were simple quality assurance activities, and now as the process of medical quality review progresses, we are moving into accreditation. Four of the health plans in the access program have had accreditation surveys by the National Committee on Quality Assurance (NCQA), and others have scheduled reviews.

We are now seeing the plans moving toward a CQI process that takes a very serious look at outcomes. The plan I am with now has already developed outcome analyses on about eight different DRGs and major diagnostic categories, so the quality assessment process is maturing in the Medicaid program at a rate that is perhaps even faster than it is in private fee-for-service medicine, so our experience was very good.

Mr. MCCRERY. Thank you.

Mr. McDERMOTT. As someone who wrote the Washington Basic Health Plan which now has 175,000 people in managed care between 100 and 200 percent of poverty in the State of Washington. I am thankful that you have come in here and presented your experience.

One of the programs in the State of Washington that we started a long time ago just won a Nova award from the American Hospital Association. It is a rural plan put together by a couple of physicians up in the rural part of our State. The managed care issue,

I think, is adaptable in a lot of places, and it is good to have people like you come, spend the time, and share your experience with us. We really appreciate your coming.

The meeting is adjourned.

[Whereupon, at 4:10 p.m., the subcommittee was adjourned.]

[Submissions for the record follows.]

**TESTIMONY OF CHARLES W. STELLAR
AMERICAN MANAGED CARE AND REVIEW ASSOCIATION**

Mr. Chairman and Members of the Committee:

On behalf of the membership of the American Managed Care and Review Association (AMCRA), I am pleased to have the opportunity to submit written testimony for the hearing record. AMCRA is the national trade association representing over 500 managed care organizations providing health care services to more than 75 million Americans. AMCRA represents the full spectrum of managed care organizations, including Health Maintenance Organizations (HMOs), Independent Physician Associations (IPAs), Preferred Provider Organizations (PPOs), Utilization Review Organizations (UROs), and Foundations for Medical Care (FMCs), providing Americans with a choice of health care plans that emphasize the appropriate use of health care facilities and services resulting in health care of the highest quality at affordable cost. AMCRA also includes a broad-based membership of allied health care professionals who provide services to the managed care industry.

The AMCRA membership has long been a proponent of comprehensive health care reform based on the principles of "accessibility, affordability, and accountability," and advocates for coverage that includes a standard package of benefits that is community-rated and guaranteed renewable without the inhibition of pre-existing condition exclusions. AMCRA recognizes the complexities of our existing, convoluted health care delivery system which stifles opportunities for expanded access, cost control, and greater parity of coverage among all individuals. But the problems of financing current and expanded access to health insurance, immediate restraint of skyrocketing costs, and reduction of the gargantuan federal deficit seem to override the obvious, easiest, and most immediate solution -- managed care. The AMCRA membership challenges Members of Congress to closely examine *why managed care works*, and how managed care will play a crucial role in reforming America's damaged health care delivery system.

WHAT MAKES MANAGED CARE WORK?

As an industry, managed care:

- Provides cost-effective, quality health care within an organized delivery system, through a network of physicians, hospitals, pharmacies and other health care providers;
- Successfully operates within an organized delivery system, using equitable and cost-effective financial incentives for all providers, with assurance that appropriate care is provided and quality is maintained;
- Selects primary care and specialist physicians who have met stringent criteria and standards for credentialing. Managed care physicians are consistently monitored for quality of care and outcomes performance, in order to retain only the best physicians within the network. Many organizations directly correlate physician reimbursement with patient satisfaction;
- Implements and actively supports preventive care, including wellness and prenatal programs, immunizations, and annual physicals;
- Coordinates and establishes cooperative programs with community-based health programs, such as *HeadStart* and *Women, Infants, and Children*;
- Offers savings of 10 to 15 percent. Managed care premium increases for 1991 were reported to be one-half the increase for traditional indemnity plans;
- Is prepared to welcome the millions of currently uninsured into already established health care delivery networks;
- Promotes administrative simplification by reducing the level of inefficiency and paperwork in the existing system;

- Provides quality health care through the implementation of effective reporting outcomes; utilization management techniques; physician credentialing; and accountability standards.

MANAGED CARE PRODUCES SIGNIFICANT COST SAVINGS

In the latter part of 1993, the AMCR Foundation commissioned the independent research firm, Health Care Strategy Associates, Inc. (HCSA), to conduct a survey of overall cost savings realized by managed care entitled, **"Managed Care Cost Containment: A Review and Reassessment."** The conclusions drawn by HCSA as a result of extensive research are startling when contrasted with the findings of a July, 1993 Congressional Budget Office (CBO) study which claims that only the strictest forms of managed care -- staff and group model HMOs -- save money, and that these models only produce an initial one-time savings by enrolling younger and healthier individuals.

HCSA found that HMOs achieved savings of 27.1 percent beyond traditional fee-for-service plans, resulting in national health care cost savings 24 percent higher than those projected by CBO, or \$15.5 billion. Furthermore, HCSA determined that if HMO savings rates, derived from the literature review, are applied to the insured population not yet enrolled in HMOs, there is an additional, or net, reduction in national health expenditures of \$81.4 billion; in other words, savings *in addition to* those already being achieved for individuals enrolled in some form of managed care. This represents a net savings of 12.2 percent and a reduction in national health expenditures as a percent of GDP from 12.1 percent to 10.6 percent. The findings also dispute CBO's contentions that reduced costs achieved under managed care represent a one-time savings and that managed care cost savings have diminished over time.

HCSA researchers based their conclusions on a comprehensive literature review of all managed care cost analyses published since 1985. The CBO study, in stark contrast, based its estimate on results of the Rand Health Insurance Experiment, which tracked the cost of treating enrollees in **only one HMO** during the late 1970s. Further, CBO's literature review did not consider seven key studies utilized by HCSA to evaluate managed care savings, which were well designed, controlled studies. HCSA chose 1985 as the cut-off year because of the rapid change and growth that has taken place in the managed care industry; which, in turn, makes the results of studies using earlier data irrelevant for quantifying current savings levels.

Furthermore, the results of the HCSA study find that HMOs have a large and consistent impact on health care costs and utilization, mainly through less admissions and shorter lengths-of-stay, while, as expected, ambulatory utilization is generally increased. The net effect is a strong reduction in overall costs.

Moreover, contrary to the CBO's contention, there is no evidence that HMO savings differ substantially by model type. Substantial Independent Physician Association (IPA) model savings were demonstrated through a variety of high quality studies.

The savings achieved by managed care organizations do not represent one-time savings, as evidenced by the continuing gap in premiums between fee-for-service and managed care premiums, as well as the fact that managed care savings rates demonstrated in the literature have shown no decline. Studies supporting the one-time savings thesis are based on old data and rely heavily on premium data, which is subject to various confounding factors, such as cost shifting and market pricing idiosyncrasies.

Clearly the CBO study reiterated some common assumptions about managed care savings that are based on anachronistic notions of managed care held over from the 1960s and 1970s which are simply not supported by evidence. AMCR urges members of the Health Subcommittee, and all Members of Congress, to carefully examine the study **"Managed Care Cost Containment: A Review and Reassessment,"** and to give equal consideration to the conclusions contained within, when considering the results of other outmoded studies.

MANAGED CARE ORGANIZATIONS MAINTAIN HIGH QUALITY STANDARDS

In spite of managed care's demonstrated ability to control costs, studies prove that quality is in no way sacrificed. In fact, a June, 1992 Gallup Organization study revealed that members of managed care plans expressed a 94 percent satisfaction rate with the quality of medical care received and an 92 percent satisfaction rate with the quality of primary physician medical care. AMCRA believes that *quality is the single most important element* in any successful managed care system. Appropriate, quality care is actually more cost-effective and beneficial to the enrollee. Managed care emphasizes preventive care and early detection of disease, reduces barriers to care, and continuously evaluates quality through extensive quality assessment programs.

Unlike fee-for-service, managed care collects the data and information necessary for assessing quality of care. As employers and payers are demanding "value" in health care -- the balance between cost and quality -- managed care organizations are meeting the challenge by expanding the systems and standards (both internal and external) to measure, report, and compare their quality and performance. AMCRA wholeheartedly endorses the establishment of uniform data sets and believes that quality indicators, such as Electronic Data Interchange (EDI) and HEDIS 2.0 (Health Plan Employer Data and Information Set) should be performed as a part of comprehensive health care reform, and that uniform claim forms and electronic claims filing should be utilized. HEDIS 2.0 quality measures cover preventive care, prenatal, chronic disease management, mental health, access, and member satisfaction. These standards are the result of a collaborative effort of numerous health plans, employers, and the National Committee for Quality Assurance (NCQA).

Utilization Management as a Component of Quality Health Care

Utilization review, coupled with quality assurance functions, equals what managed care organizations refer to as "utilization management." Utilization management techniques practiced by managed care organizations are essential to assuring that costs are contained in a medically appropriate manner by reducing "waste" in health care services, *without lessening the quality of care delivered*. A joint medical/actuarial study has suggested that 53 percent of inpatient bed days and 15 percent of office visits in the U.S. are medically unnecessary. Studies of managed care organizations, however, have shown that much of this inefficiency and inappropriate utilization of services has been eliminated. These results are obtained through comprehensive utilization management based on clinical guidelines of medical appropriateness, close review and monitoring of physician practice patterns, and reinforced physician/plan relationships.

Utilization Management helps enrollees receive appropriate and needed care while eliminating both the expense and the risk associated with ineffective and unnecessary procedures in the following ways: providers are accepted to participate in managed care plans based on stringent criteria, and must meet more than two dozen criteria before they are accepted, plans annually review each primary care office to monitor continued compliance with these standards, and members are regularly surveyed to determine if they are satisfied with their family physicians, office procedures and follow-up care.

THANKS TO HIGH PATIENT SATISFACTION, MANAGED CARE CONTINUES TO THRIVE

The final arbiter of managed care's success is the marketplace. Increasingly, growing market share and the adoption of managed care techniques by traditional providers are *prima facie* evidence that managed care works. Several recent studies, by research firms such as Gallup and Novalis, have found that managed care enrollees are just as satisfied as fee-for-service patients, or more so, on all dimensions of satisfaction studied.

According to a Novalis study released in October, 1993, consumers in managed care plans such as HMOs are as satisfied with the quality of their health care as

consumers enrolled in less restrictive health plans. The Novalis report found that 89.7 percent of HMO members rate the quality of care delivered by their doctors as excellent or good. These ratings do not differ significantly from the quality of care ratings of consumers not enrolled in HMOs, 92.5 percent of whom rated their care as excellent or good. The Novalis study findings held true regardless of respondents' age, income, education level, or race.

Not only have individuals enrolled in managed care plans expressed satisfaction, but, according to a 1992 National Executive Poll conducted by *Business & Health*, "...employers are confident about managed care and many believe it is their only chance to control costs." Managed health care encourages open-market competition among health care providers and offers quality care by coordinating the disparate elements of the health care delivery industry. This is why major companies like Xerox, DuPont, and Southern California Edison have included managed care in their reform efforts. In rating the health plan employers currently offer in terms of cost cutting effectiveness, 69 percent of the respondents say managed care has produced the best results.

A 1992 Towers Perrin survey now offers clear evidence that the dual goals of managed care -- sustainable cost reductions and enhanced employee satisfaction -- are, in fact, attainable. Of large employers surveyed, virtually all, 91 percent, say that managed care is achieving their objectives. In the same survey, nearly three-quarters (73 percent) of the employers surveyed say that employee satisfaction with health benefits is the same, or better, under managed care.

Due to the growing demand for managed health benefits, AMCRa strongly believes that employers and consumers alike should be given the option of choosing a managed care plan to provide health care for their employees and families.

Medicare

Satisfaction with managed care is not limited to the private sector. In fact, over 25 percent of senior citizens eligible for Medicare report enrollment in managed care plans, according to a 1991 Gallup Organization survey commissioned by AMCRa. 91 percent of seniors enrolled in managed care plans are satisfied with their enrollment and would recommend their plan to others; this compares with 85 percent of seniors in traditional indemnity plans recommending their plans to others.

Furthermore, a recent Mathematica study (released February 1993) showed that Medicare HMOs appeared to reduce the intensity and frequency of medical services, especially hospital stays, without harming the quality of care. This finding supports the basic premise of managed care and suggests that with a more appropriate reimbursement mechanism significant savings could be achieved. The Mathematica study stated that "over 90 percent of enrollees rank their care [in a managed care plan] as good or excellent along every dimension."

Medicaid

Managed care has also made great strides in providing comprehensive health care coverage to millions of Medicaid recipients. Approximately 31 million Americans are covered by Medicaid. Of this amount, approximately 12 percent are enrolled in managed care, with many states, such as Florida, Hawaii, Kentucky, and Tennessee awaiting or already having received federal waiver approval. Additionally, Illinois, Missouri, and Montana are either considering moving to managed care, or have initiated demonstration projects.

Medical care is most effective when the patient develops a personal relationship with his/her primary care physician. This patient-physician relationship is the cornerstone of Medicaid managed care. Without a primary care physician, Medicaid recipients in the fee-for-service environment frequently end up in the local emergency room where they often wait for hours, while incurring hospital charges 13 percent higher and hospital stays 27 percent longer than other patients. (The Journal of the American Medical Association, October 1991). Medicaid recipients who rely on fee-for-service programs have been denied the opportunity to develop a similar relationship with a primary care doctor. The underlying causes for this are varied but include: lack of doctors in their neighborhood; inadequate transportation; low reimbursement

of physicians in Medicaid; and use of the emergency room as access to primary care.

AMCRA applauds President Clinton's commitment to easing the burden on states applying for waivers for managed care programs. However, federal law still allows states to automatically place Medicaid recipients in the fee-for-service arena, but not to automatically enroll recipients in a managed care plan without first receiving a federal waiver. Even after a state has received a waiver, it must still reapply for a continuation every two years. As such, the federal waiver process has become a barrier to innovation in the states, and congressional action is required to correct statutory assumptions which favor fee-for-service medicine over coordinated care.

Most managed care organizations have added services to their basic benefit package which is compatible with industry philosophy in providing preventive care while remaining competitive. A few of these services are inpatient mental health; prescription drugs; durable medical equipment; prosthetics; chiropractic services; podiatric services; others. However, Medicaid eligibility, criteria and benefit levels vary dramatically from state to state. The wide disparities in coverage and eligibility are due in large part to the willingness of each state to supplement the federally mandated coverage. The result is dramatic differences in coverage and eligibility between states. Therefore, AMCRA supports the establishment of minimum eligibility standards and benefit levels to standardize coverage nationwide.

Many of AMCRA's member organizations have found innovative ways to successfully care for their Medicaid enrollees. **Omnicare Health Plan** of Detroit, Michigan is a prime example. Omnicare was started with a Department of Health Education and Welfare demonstration grant in 1973 to investigate feasibility of implementing an HMO in the Detroit metropolitan area to service the Medicaid population. Omnicare has been successful in removing the stigma that has been assigned to Medicaid recipients. For example, once an individual selects Omnicare as their health insurer, while the benefits may differ, they are no longer identified as Medicaid recipients, nor as a State of Michigan employee, nor as a Ford Motor Company employee...they are an Omnicare enrollee. Several insurers will pay a lesser amount to the specialist physicians for services rendered to Medicaid members. This is not the case with Omnicare.

The following represents a few of the programs implemented at Omnicare to service its Medicaid recipients. They are: Prenatal; Asthma; Immunizations; Mammographies; Nutrition and Weight Control; High Blood Pressure; Woman, Infant and Child (WIC). All of the above programs have positively impacted the health status of Medicaid recipients covered by Omnicare.

Another successful Medicaid managed care program is **Kitsap Physicians Service**, in Bremerton, Washington. KPS has developed the exemplary Sound Care Program to foster the patient-physician relationship and to help Medicaid beneficiaries access services. As soon as a new AFDC recipient is enrolled in Medicaid, Kitsap assigns that individual to a primary care physician. KPS' Sound Care Beneficiary Advocates and visiting nurses regularly communicate with enrollees to assure that they understand and use the health care services offered them.

Wisconsin Independent Physicians Group (WIPG) of Milwaukee, Wisconsin is another health plan which has a large and successful Medicaid managed care program. WIPG has dedicated their resources to not only developing an effective prenatal support program, but also to analyzing the impact of their program. For example, a 1990 study of 1,265 deliveries identifies that the enrollees participating in the Prenatal Support Program (PSP) had fewer premature infants, a higher number of prenatal visits, shorter hospital lengths-of-stay for both mothers and infants, and lower infant mortality rates.

In demonstrating the effectiveness of their prenatal support program, WIPG's model has been utilized by the state of Wisconsin to expand prenatal services to all high-risk medical assistance recipients.

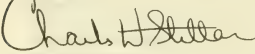
Many other AMCRA members also operate highly successful prenatal programs which include many of the following services: identification of high risk pregnancies; coordination with a health nutritionist for WIC certification and counseling; transportation, if necessary, to prenatal appointments; and visits by nurses throughout pregnancy of high risk members, with each visit focused on teaching and assessing prenatal physiologic changes and complications which may occur. By implementing these types of programs, managed care provides effective prenatal care. For instance,

Omnicare experienced a 50 percent reduction in the number of premature infant births from 1990 to 1992 as a result of its Prenatal Homecare Program.

CONCLUSION

The many providers of Medicaid managed care programs across the country would be honored to come before this committee to elaborate on the intricacies of their programs. Thank you for the opportunity to offer the committee the opportunity to demonstrate that managed care does, indeed, provide low-cost high quality health care to an ever-growing and satisfied number of Americans. Please do not hesitate to contact AMCRA if we can provide further information.

Respectfully,

A handwritten signature in dark ink, appearing to read "Charles W. Stellar". The signature is fluid and cursive, with the first name "Charles" being the most prominent part.

Charles W. Stellar
President

STATEMENT
of
AMERICAN PAIN SOCIETY
AMERICAN ACADEMY OF PAIN MEDICINE
AMERICAN ASSOCIATION FOR THE STUDY OF HEADACHE

This statement is submitted on behalf of the American Pain Society, the American Academy of Pain Medicine, and the American Association for the Study of Headache. These three organizations represent clinicians and researchers who treat the nation's intractable pain patients, including those with cancer, migraine, back pain, and many other conditions.

BACKGROUND

Intractable pain is a serious public health problem in the United States, yet it is virtually unrecognized. It is an invisible disability affecting major segments of society. Fifty million Americans are partially or totally disabled by pain, and 45% of all Americans will seek care for persistent pain at some point in their lives. While headache and low back pain are the most prevalent forms of intractable and persistent pain, pain accompanies a wide range of clinical conditions including cancer, diabetes and arthritis. Pain imposes enormous costs on the patient, the economy, and the health care system. Intractable pain impacts dramatically on the quality of an individual's life and the ability to function. Productivity losses due to pain are estimated at \$85-90 billion per year. 150 million workdays are lost annually to head pain alone. Of the estimated 400,000 back surgeries performed annually, only a fraction appear necessary in pursuit of pain control. 22% of work-related injuries involve persisting pain. Even children lose one million school days annually due to pain.

The President's health care reform proposal, as well as several alternate proposals under consideration in the Congress, rely to varying degrees on "managed care," both to reorganize the health delivery system, and as a tool to control costs. In this respect, such proposals would put the weight of Federal policy behind a trend which is already rapidly accelerating in the private sector. This trend is most pronounced in capitated HMOs and PPOs, but increasingly even those employers and insurers who purport to offer "traditional" fee-for-service indemnity coverage, couple that coverage with either economic incentives or administrative controls to manage the delivery of services.

These incentives and controls take many forms: closed provider systems, preferred provider networks, "gatekeepers," pre-admission screening, pre-authorization for tests, procedures and referrals, after the fact utilization review, and policy limits, either express or *de facto*, on the number and frequency of services.

Incentives are ostensibly directed at patients, offering economic rewards for judicious use of resources and the choice of lower cost providers. In fact, many hidden incentives apply to physicians, hospitals, and system managers who are financially rewarded for not ordering tests, not doing procedures, not referring to specialists outside the primary network, and not keeping patients

in the hospital. Bluntly put, if traditional fee-for-service medicine sometimes put greed on the side of over-utilization, managed care organizations sometimes put greed on the side of under-utilization.

Managed care is the reality in health care in the 1990's. So the issue in health care reform is not whether there will be managed care, but how care will be managed, by whom, and for who's benefit?

MANAGED CARE: THE PAIN PATIENT'S PERSPECTIVE

Based on experience to date in the private sector, managed care raises serious issues of consumer protection for patients suffering from intractable pain and similar illnesses. Certain illnesses are not effectively treated in tightly controlled systems emphasizing primary care. They are frequently misdiagnosed or undiagnosed. Patients are frequently mismanaged or untreated. "Gatekeepers" can become "jail keepers," impeding rather than facilitating early intervention. These cases stand out, they are widespread, and they require special consideration in any federal reform legislation.

Intractable pain, like other complex illnesses, can be effectively treated in most cases, but it requires early intervention by appropriately trained specialists in appropriate settings. The Clinton plan focuses on primary preventive care, but serious illness and injury will nonetheless occur. The plan ignores the important role of specialty care and secondary prevention - preventing the avoidable complications or deterioration, and restoring health and function where possible, by aggressive, comprehensive, outpatient advanced care interventions. For pain, secondary prevention includes preventing addiction, depression, disability, needless surgery, and repetitive testing, among others.

Those who treat intractable pain see the dark side of both over-managed and under-managed care.

They treat patients who are in desperate search of relief and require intense and experienced intervention, but who have been needlessly delayed or denied access to such care by primary care "gatekeepers" who either do not understand the problem, are insensitive to it, or flatly refuse to refer such a patient, sometimes for their own economic gain. When gatekeepers do try to refer, insurance administrators sometimes reject the referral, also for economic reasons. As with justice, in the case of intractable pain, treatment delayed is treatment denied. It leads to more costly interventions later, and avoidable suffering and human travail. Patients often desperately seek care, approved by their systems or not. Quality of life can be stabilized or restored. Function can be improved, and yet payment for such services is routinely denied by managed care organizations because it is not preauthorized or it is not part of the right "network." And when managed care systems do approve payment, they want to pay doctors for usual and customary care, not interdisciplinary teams for advanced care and management of complex cases.

The cost of mismanaging complex cases is tragic in human terms, and excessive in financial terms. Patients frequently become drug addicted and disabled, as much from their treatment, as from the underlying cause. As desperate as is the patient, so too is the primary care physician who in an effort to relieve the suffering, prescribes narcotic or other interventions which inadvertently contribute to and confound the problem.

Individual patients illustrate the problem:

- A 44-year old man suffered severe, intractable head pain following the successful removal of a brain tumor, but his managed care organization had denied repeated referral requests by his treating physicians. He funded his own care at an advanced center, was successfully treated and returned to work. He still had to wage legal warfare for his services to be covered, despite having been unsuccessfully treated over and again by specialists in his own health care system.
- A 35-year old man from Canada underwent four destructive surgical procedures on his face for relief of pain, and was referred to an advanced center five years after his pain began. By then, he was taking 57 Tylenol with codeine per day.
- A 44-year old Michigan woman suffering from head and neck pain following a motor vehicle accident spends at least \$40,000 on various health care services, and is referred only after years of addiction to increasing amounts of narcotics.

These patients and countless others could have been helped. But they suffered for years the needless agony, personal consequences, and costs of delayed, ineffective treatment and the complications of inappropriate intervention.

Public policy must distinguish between those cases of complex, chronic illnesses, such as substance abuse, intractable pain, and mental health problems that require time-critical, advanced levels of care, and those more routine, standard medical conditions which are appropriately managed on a primary care level. It must also distinguish between specialists who treat patients by personal intervention and clinical skills, and those specialists who deliver high-tech, procedural diagnostic and treatment services.

Reform plans that rely heavily on managed care systems should incorporate the following principles to deal with intractable pain and similar illnesses:

- Fee-for-service and point of service options should be real - not subject to waiver by states, alliances or plans, or to unreasonably high cost sharing.
- Qualified health plans must guarantee patient access to, and actually deliver, either directly or through relationships with appropriate referral centers, the specialty care required.
- Gatekeepers in qualified health plans must be properly trained for the clinical judgements they are asked to make, and accountable for those clinical judgements. They must not be financially rewarded for undertreating the patient.
- Referral arrangements for intractable pain and similar complex illness must be targeted to properly trained professionals, academic centers, and other centers of advanced care at a time when cost effective interventions and secondary prevention are most likely to succeed. While the Clinton plan briefly acknowledges "centers of excellence," the concept must be developed responsibly and in greater detail. Advanced, credentialed

levels of care offer human and cost advantages for patients with complex, high cost, intractable illness. The Clinton plan also includes important provisions for academic health centers, but the treatment dollars are directed at inpatient teaching hospitals. Criteria are available to identify high quality, credentialed ambulatory (outpatient) centers that have comparable or even greater expertise in particular illnesses. These centers can often provide that expertise at a far lower cost, and with the aim of maintaining patients out of hospital settings through aggressive and comprehensive outpatient strategies and intervention.

- Qualified health plans should be required to use provider fee schedules that recognize the scope and intensity of services delivered by advanced care systems and practitioners, and multi-disciplinary teams to patients who fail to respond to customary and usual care.

Alice Lusk
Corporate Vice President



February 4, 1994

The Honorable Pete Stark
Chairman, Health Subcommittee
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington, DC 20515

Dear Chairman Stark:

Nearly two years ago, in April 1992, I had the opportunity to testify before members of your subcommittee on administrative simplification. EDS appreciates being able to provide additional input on that subject, in the form of this letter, to the record of the February 2nd hearing on President Clinton's Health Security Act.

The issues that were driving administrative reform two years ago are even more pressing now. Health care costs will exceed \$1 trillion this year and there are two million more uninsured persons than there were in 1992. Health care delivery continues to be fragmented and bureaucratized, to the point of extreme exasperation on the part of doctors and their patients. In the absence of good information and measures, our knowledge about the quality of care provided to both the insured and the uninsured remains extremely limited, as does our ability to impact the processes and outcomes of care.

When I testified to your subcommittee, I described how information technology (IT) can be leveraged to help solve our nation's most pressing health care problems. At a minimum, IT can be used to reduce both hassle and waste in the administration of health benefit programs. Far more importantly, IT can support information-driven decision making in the delivery of health services to improve the quality of care, while optimizing the use of health resources.

Ironically, health care is one of our most information intensive industries, yet historically it is one in which IT has been taken advantage of the least. Each encounter with the health care system--and there are well over a billion each year--generates massive volumes of data: medical, financial, and administrative. Most of these data, however, have been captured and stored on paper--in hundreds of different formats--making them difficult to retrieve, aggregate, and analyze. As a result, our ability to generate useful information to support coverage and care seeking decisions of patients and treatment decisions of providers has been sharply curtailed.

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Fortunately, all that is changing. Faced with growing competitive and financial pressures, health care delivery systems and insurers are re-engineering their business practices and re-tooling their workforces. Information technology and connectivity have become the centerpiece of many of these restructurings.

While the first wave of health industry connectivity has been focused on streamlining claims submission and payment, increasingly these networks will be used to share clinical information for direct patient care and research purposes. Already, high speed communication lines are enabling physicians in some parts of the country to transmit radiographic images (e.g., x-rays, MRIs, CAT scans) to colleagues around the country for immediate consultation.

Two years ago, you were one of the few members of Congress who recognized and understood the value of IT in simplifying the administration of our health care system, as reflected in your legislation, H.R. 4956. Today, thanks in part to your early leadership, virtually every comprehensive reform measure, including the Health Security Act, contains provisions designed to simplify the administration of our health care system and improve the data upon which our health care decisions are based.

EDS supports limited government intervention to facilitate the development of a nationwide health care information infrastructure. It is our belief that a few key actions by the federal government will hasten the development of a technological infrastructure that can be leveraged not only to simplify the administration of our health care system, but also to generate the information needed to bring about marked improvements in the quality and cost-effectiveness of health care delivered in this country.

Of all the legislation that has been drafted to accomplish these objectives, EDS feels most comfortable with the approach set forth in the bipartisan, bicameral "Health Information Modernization and Security Act" introduced by Senators Bond and Riegle and Congressmen Hobson and Sawyer. This legislation, S. 1494/H.R. 3137, would assure an explicit public-private partnership in all aspects of our national health information infrastructure.

With guidance from the private sector, a federal Health Care Data Panel would adopt standards for the electronic exchange of health data related to enrollment, eligibility, quality measurement, utilization management, risk assessment, patient satisfaction, outcomes, access to health services, and other data sets deemed appropriate by the panel. Except for some small and rural hospitals, all participants in the health care system would have to comply with these standards within specified time periods, or face civil penalties established by the Panel. The Panel would also set forth criminal and civil penalties for violating the privacy and confidentiality requirements of the bill. The Department of Health and Human Services would monitor the private sector implementation of standards and would establish and oversee a certification process for database, computer and network vendors to assure they are complying with the standards and the privacy and confidentiality requirements specified in the bill.

Under S. 1494, the primary role of the federal government would be to eliminate barriers to the creation of the infrastructure and to assure compliance through the establishment and

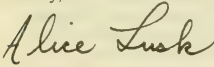
implementation of a realistic monitoring and enforcement mechanism. All federal and state health programs would be required to use the same standards as the private sector, thereby ensuring interoperable networks and consistency of data. The private sector would be given the rules of the road and would be encouraged to build upon existing infrastructure, thereby minimizing expensive and unnecessary redundancy. The legislation is technology neutral, allowing maximum flexibility to incorporate enhancements and new technologies as they are developed.

Before closing, I would like to stress the importance of immediate Congressional action on preemptive legislation to protect the privacy and confidentiality of all personal medical data. As demonstrated by the findings from a recent Louis Harris/Equifax survey, the American public has grave concerns about the computerization of their medical data, fearing these data will be more vulnerable to misuse. Ironically, computerized patient data can be made far more private and secure than paper-based records. Until, however, the Congress enacts preemptive legislation to rationalize the current patchwork of state laws governing the privacy of medical data, it will be impossible to achieve the protections and efficiencies possible through computerization of our health care system.

The Workgroup on Electronic Data Interchange, the Institute of Medicine, the American Medical Association, the American Hospital Association, the American Civil Liberties Union, and the American Health Information Management Association are among the many organizations calling for preemptive privacy legislation, and we urge you do the same. With appropriate Congressional guidance on key policy issues, such as what constitutes an invasion of privacy; what types of information should be protected and to what degree; what constitutes authorized access/use; and penalties for violations, it will be possible to take advantage of technology to meet these requirements in a cost-effective manner. In the absence of this policy guidance, systems will be built now that may not meet future requirements. The cost of retrofitting these systems with privacy features could be prohibitive.

EDS stands ready to work with you, your Congressional colleagues and the Administration in passing administrative simplification and privacy legislation during the 103rd Congress. I urge you to ensure the passage of these items this year so we can hasten the building of the national infrastructure necessary to support a more efficient, effective health care system.

Sincerely,

A handwritten signature in cursive script that reads "Alice Lusk". The signature is written in dark ink and is positioned below the word "Sincerely,".

Alice Lusk

**Testimony
Submitted to the
Subcommittee on Health
Committee on Ways and Means
February 28, 1994**

by

**George C. Phillips, Jr.
President, HealthNetwork, Inc.
Representing HealthNetwork, Inc.,
The American Association of Preferred Provider Organizations,
and The American Managed Care and Review Association.**

Current Health Care Reform Debate

Currently, at least eight health care reform bills have been drafted in an effort to repair and restructure the \$900 billion health care industry. While these bills vary significantly in terms of philosophy and approach, many of the proposals before Congress strive toward such common goals as greater medical cost containment, broader access to the health care system and improved quality of care. Another common thread is evident in most of the reform packages that incorporate a structure of managed competition – that is, a heavy emphasis on the style of managed care commonly associated with Health Maintenance Organizations (HMOs).

Although many individuals associate the concept of managed care with HMOs, there is an alternative type of managed care company which should also be factored into the reform equation – an alternative known as Preferred Provider Organizations (PPOs). Like HMOs, PPOs are designed to effectively control medical costs and monitor the quality of care. In addition, however, PPOs offer several key advantages that are not available in an HMO environment, such as freedom of provider choice. Any health reform measure that seeks to successfully incorporate the concept of managed care must feature a prominent and clearly defined role for the PPO.

Preferred Provider Organizations

Despite the fact that much of the health care debate has centered around HMOs, PPOs are actually the most popular form of managed care in the United States today. According to the American Managed Care and Review Association (AMCRA), over 54.4 million American workers are enrolled in PPOs, while HMO enrollments stand at slightly more than 44 million. In addition, the number of PPOs operating in this country currently exceeds HMOs by the wide margin of 895 to 566.

The popularity of PPOs continues to grow at a rapid pace. By the end of 1993, 33% of all employees at small businesses were enrolled in PPOs, up from 28% in 1992. And, nearly one-quarter of all workers at large employers received their health care through PPOs in 1993.

PPOs have achieved such high levels of acceptance from the American public and the business community because they offer the most effective combination of cost savings and freedom of provider choice.

From a cost standpoint, PPOs have proven to be instrumental in controlling medical expenses. In fact, according to a recent study by the consulting firm of A. Foster Higgins, PPOs were the most effective of all health care plans in holding down costs in 1993. Last year, PPO costs increased by just 5.5%. During that same time period, HMO costs increased 6.5%, and the cost for a traditional indemnity plan jumped 7.1%. This is strong evidence of the PPO's ability to achieve one of the primary goals of health care reform – effective medical cost containment.

PPOs control medical spending through three primary vehicles:

1. Negotiated rates on health care services. PPOs develop networks of physicians, hospitals and ancillary care services that contractually agree to deliver medical services at reduced prices.
2. Utilization Management programs. PPOs closely monitor patient care to ensure that services are medically necessary and cost-effective. Many PPOs also track network utilization patterns in an effort to better manage the volume, cost, quality and outcomes of the health care services rendered by participating providers.
3. Health intervention services. HealthNetwork, Inc. is one of the nation's first PPOs to introduce health intervention programs as a means of further managing health care expenses. This service begins with an in-depth analysis of the historical claims data of an employer group to identify those lifestyle factors which are generating unnecessary and excessive health claims. Specific services are then developed to modify individual behavior over the long-term and reduce the need for medical services.

In addition to controlling health care costs, PPOs also provide more choice than other forms of managed care. Unlike HMOs, for example, PPOs provide members with freedom of choice when it comes to selecting a medical provider. Throughout the debate over health care reform, the American public has clearly stated its desire to select their doctor or hospital of choice when medical care is needed. PPOs allow this choice by enabling members to visit any provider in the PPO network. Also, PPO members can typically receive care from out-of-network providers without severe limitations on their health benefits coverage. Through this structure, PPOs help to achieve another key goal of health reform – consumer choice.

The Role of Health Alliances

Many of the proposed reform bills before Congress incorporate the concept of large purchasing cooperatives, known as health alliances. These alliances, however, are not necessary for the success of any reform plan and should not be included in final reform measures for several key reasons:

1. Alliances will create a government bureaucracy which will work against the

goal of a more efficient, streamlined health care system.

2. The costs involved with establishing and maintaining these alliances will be prohibitive.
3. Alliances may contribute to the problem of "cost shifting" in which higher medical costs are passed along to individuals and employers not covered through the alliance.
4. Additional costs may be required for managed care companies to interface with alliances.

The high costs associated with these alliances may be evidenced in recent projections made by the Congressional Budget Office. In this analysis, the CBO estimates that the Clinton reform plan – which relies heavily on alliances – would actually increase the federal deficit by \$74 billion instead of producing a \$58 billion deficit reduction as originally predicted.

Instead of alliances, employers should have the option of forming coalitions with other employers as a means of obtaining greater purchasing power and gaining more control over medical costs. Such coalitions would also help to strike a better balance between the high health care expenses paid by small business and the lower costs associated with larger corporations.

If, however, alliances are ultimately deemed an essential part of health care reform, one important distinction needs to be made. Participation in alliances should be reserved only for those companies with 100 or less employees, and enrollment in these government-controlled entities should be strictly voluntary with no regulatory authority. Why target smaller companies for health alliances? Since most larger employers are already effectively managing their medical costs through PPOs and other managed care programs, there is no reason to mandate a switch to these alliances.

In addition, the concept of global budgets should not be pursued as a cost containment solution. Such price caps have proven to be ineffective in the past and will not be successful now or in the future. Global budgets also carry the potential for the rationing of care, an undesirable outcome that must be avoided by any reform package that is ultimately implemented.

Insurance Reforms

Access to health care continues to be a problem that plagues the industry. Much of this problem can be resolved, however, through two crucial changes in the area of health insurance coverage:

1. Guaranteed renewability and portability for individual policyholders.
2. Elimination of pre-existing condition limitations which currently restrict access to medical coverage.

These two insurance-related revisions – coupled with reforms in the area of medical malpractice – will have a positive impact on medical cost controls and

access to quality, affordable health care services.

It is also believed that the uninsured and underinsured of this nation should be addressed as a separate group from the rest of the population that is currently accessing and benefitting from our nation's health care system.

PPO Licensing Issues

As PPOs continue to evolve to meet changing market demands, many PPOs are considering the possibility of bearing financial risk as part of their operations. However, model legislation currently being drafted would require PPOs to obtain HMO licensure if they wish to take on such financial risk. This expensive and unnecessary step may inhibit many PPOs from making the changes and adjustments needed to keep pace with industry demands for greater cost containment.

To address this issue, it seems reasonable to modify existing PPO state legislation so that PPOs can bear risk and develop new cost containment programs under their current PPO licenses. Such modifications in licensing should also include reciprocity, so that licenses apply to all states in which a PPO operates. This is an issue that must be addressed by the National Association of Insurance Commissioners.

Conclusion

More than 54 million American workers are currently enrolled in PPOs across the country. After spouses and dependents are factored in, this figure grows to an estimate of more than 120 million Americans who are eligible to receive medical care through a PPO – 120 million Americans who recognize the PPO's ability to manage medical costs on the one hand and offer freedom of provider choice on the other hand. It is this combination of savings and selection that has contributed to the explosive growth in PPO enrollment over the past several years.

As Congress considers the many reform proposals that have been developed, the focus should remain on providing a health care system in which informed consumers are free to choose a qualified, affordable medical provider. A health care system based on efficiency and simplicity instead of bureaucracy. A health care system which thoroughly addresses the critical issues of cost, quality and access, without the implementation of price controls and global budgets.

In other words, Congress should strive toward the health care system of tomorrow that incorporates many of the qualities that can be found in the PPOs of today.

STATEMENT OF THE NATIONAL ASSOCIATION OF REHABILITATION FACILITIES
 SUBMITTED TO THE SUBCOMMITTEE ON HEALTH
 COMMITTEE ON WAYS AND MEANS
 FOR THE RECORD OF THE HEARING ON HEALTH CARE REFORM:
 ISSUES RELATED TO MANAGED CARE

Mr. Chairman:

I am Rob Schwartz, President of the National Association of Rehabilitation Facilities (NARF). NARF is a national organization representing over 900 members who provide medical, vocational, residential and employment services to over 4 million people annually.

We are pleased that the Subcommittee is addressing managed care in the context of health care reform. Many of the health care reform proposals rely upon market place competition which places a heavy emphasis on managed care to restrain costs. We have serious concerns about how managed care companies have treated rehabilitation services and providers. Given that the Congress and the President are examining how to redesign and reinvent our health care system, we have an opportunity to correct the problems of the present and make certain they are not carried forward into this new future.

All of us will probably need at least one rehabilitation service sometime in our life. As we go about our daily lives none of us contemplate if we will have a stroke, break a hip, hit our head, have a spinal cord injury, be shot or stabbed or have a child born with a congenital problem. We do not think about this as our future. But for many Americans, unexpectedly and unfortunately these things happen. These types of illnesses or injuries require rehabilitation services to help return people to home, to work, to school and ideally to an active life. For a child born with a congenital or genetic disorder, rehabilitation services can help them walk, move, write, feed themselves, and therefore attend school, participate in social events and enjoy the kind of life that most of us think is what life is all about.

BACKGROUND ON REHABILITATION

Rehabilitation services are an integral part of our American health care system. They are very cost effective. For example a Northwestern National Life study shows that for \$1 spent there is a savings of \$30.00.

Rehabilitation involves specialized physicians, rehabilitation nurses, physical and occupational therapists, speech language pathologists, respiratory therapists, social workers, psychologists, and other therapists who work as a team with patients to restore their functional ability and help them be independent. This interdisciplinary team concept is central to rehabilitation and the sum of these efforts is greater than the parts. The team establishes an individual rehabilitation plan which sets forth that person's goals in rehabilitation. For example, a person has had a stroke which impairs the ability to walk, see, swallow and creates weakness on the left side. The goals include walking again independently, swallowing without aid, seeing well enough to read, strengthening the left side so the arm and leg can be used, and being able to dress independently again. Over 80% of the 4 million people receiving rehabilitation services return to their homes, work, schools or an active retirement. Common conditions usually requiring rehabilitation include: heart attack, stroke, arthritis, cancer, neurological disorders, joint fractures and replacements, amputation, head injury, spinal cord injury, chronic pain, pulmonary disorders, burns, multiple trauma and congenital or developmental disorders.

Rehabilitation is delivered in freestanding rehabilitation hospitals, rehabilitation units of general hospitals, comprehensive outpatient rehabilitation facilities, rehabilitation agencies and other outpatient settings, skilled nursing facilities and in people's homes. Determining which setting is appropriate is a function of medical judgement. These settings provide a full continuum of rehabilitation care.

The rehabilitation field is responding to the changes in the health care field. It is becoming more cost effective through the use of critical pathways, decision rules and constant examination of the use of resources and outcomes. All of these practices help make decisions about the appropriate use of resources.

EFFECTIVENESS OF REHABILITATION

If rehabilitation services are delivered, they are most effective if delivered early after trauma or illness. For example, rehabilitation is one of the evaluations done right in the trauma center. If an appropriate referral is not made the person remains dependent, the family suffers and society, the individual and the family pay more than just financially. In a study of the cost benefits of stroke, the investigators found that for each stroke patient who, through rehabilitation, was able to live at home, the expense of living at home versus in a nursing home setting saved \$13,248 per year in 1981 dollars, or \$20,447.61 in 1992 dollars per year. Given that the average stroke patient lives over 5 years this is a savings of \$102,238.12 in 1992 dollars.

A recent article in the October/November/December issue of TQM magazine, "Judging the Cost-Effectiveness of Rehabilitation", discussed the cost effectiveness of rehabilitation. Pulmonary rehabilitation improves patient function and reduces the use of medical services. Early rehabilitation in a rehabilitation unit for stroke patients is more effective than for patients treated on general medical wards. Twice as many of the patients who did not receive rehabilitation went to nursing homes and the mean time in an institution in the first year, including nursing homes was 75 days for the rehabilitation patients and 123 days for the patients who did not get the rehab program.

For traumatic brain injury (TBI) early initiation of rehabilitation can save costs. A recent study compared patients from one hospital with an aggressive early rehabilitation program for TBI with those from 11 other hospitals without organized programs. Patients from the formal program experienced one third the time in a coma. Also the rehabilitation length of stay averaged 54 days vs. 106 days for those coming from routine care. Ninety-four percent (94%) were discharged home in the early intervention program compared to 57% of the others. Again, there is an enormous amount of money saved simply by calculating the cost of days **not** spent in the hospital.

We are, Mr. Chairman, like you, concerned about the rehabilitation care, or lack of it, and the quality of rehabilitation services some Medicare and non Medicare HMO enrollees, are receiving.

ISSUES

These concerns address the following issues:

- * coverage of rehabilitation services and providers;
- * incentives not to refer for specialty services;
- * the quality of rehabilitation services provided; and
- * potential violation of the Americans with Disabilities Act.

I. Coverage

According to the Group Health Association of American the majority of HMOs provide coverage of individual rehabilitation services. However coverage varies among

plans. The California Association of Rehabilitation Facilities found great disparity among plans in coverage of rehabilitation services regardless of the site of services.

The ambiguous regulatory language on outpatient services and inpatient rehabilitation hospital services required to be delivered by federally qualified HMOs and its interpretation and implementation by many HMOs, federally qualified or not is a problem. Others reasons there are problems with coverage are because HMO's restrict referrals even if rehabilitation is covered as part of their efforts to save money and, in at least one case, the policy specifically excludes rehabilitation.

The HMO regulation at 42 C.F.R. 417.101, regarding the basic health services which HMOs must provide, state that "outpatient services and inpatient hospital services shall include short term rehabilitation services and physical therapy the provision of which the HMO determines can be expected to result in the significant improvement of a member's condition within a period of two months".

We have several problems with this regulation. First is the interpretation of what constitutes a day for measuring the two month period. Some HMOs provide physical therapy at bedside while the patient is in the acute care setting and call it one full day of rehabilitation services and deduct it from the two months. Hence when the patient goes to a comprehensive rehabilitation program there are few days left in which to deliver the comprehensive program and achieve maximum functional gain.

Second, many HMOs read the two month period as a maximum when it is not. Such a time limit is arbitrary and restricts the availability of services. Many people who can continue to make solid rehabilitation gains, returning them to a productive life, are not able to do so. Under the best construction of this regulation, it does not provide for 60 days of coverage but only for services that will lead to significant improvement within 60 days based on the HMO's judgement.

A NARF survey found that of those HMOs that referred enrollees to rehabilitation hospitals and units and limited the number of days, the average number of covered days was 58. Sixty nine percent (69%) of the rehabilitation hospitals and units to which HMOs referred Medicare patients reported that the HMO limits the numbers of days of therapy, with an average limit of 51 days. We find this information about Medicare beneficiaries particularly disconcerting because it is our understanding that the Medicare package of benefits is to be available to Medicare rehabilitation patients. Under Medicare there are no day limits on therapies or programs. Medical necessity is determined by the Medicare inpatient rehabilitation hospital guidelines.

Here are a few examples. A man fell off his bike in Arlington, Va. and incurred a severe spinal cord injury. His insurer, an HMO, will cover his rehabilitation hospital stay for only two months. His physician says it will take him three months to complete his full program, be stabilized and be discharged. The standard for treating spinal cord injuries is quite well established now in this country with fairly well known outcomes - if the individual can receive the proper care at the right time. The true irony is that he was to be discharged on Valentine's Day.

In California, two men had similar spinal cord injuries. One had commercial insurance; the other was insured by an HMO. The man with commercial insurance received his full rehabilitation program in a rehabilitation hospital and outpatient settings and returned to his work, his family and an active life. The man with HMO coverage was taken out of the hospital and sent to a nursing home where he lost all previous gains from rehabilitation and was left in bed, turned once a day. He is at risk for deep vein thromboses, pneumonia, and skin break downs.

Recommendation: Under any health care reform proposal:

- (1) The two months limit for rehabilitation services should apply to 60 days of services in a comprehensive rehabilitation program vs. uncoordinated, single discipline services.
- (2) The two month period should not be viewed as a maximum, but as a period for reevaluation of the need for an additional 60 day period of services if function is improving or to prevent deterioration of function as seen in the patient's record, not at the HMO's discretion. The reevaluation should be conducted by the professional treating the person and a representative of the HMO if the HMO so desires. The existing Medicare guidelines should be used.
- (3) The regulation cited above and limits on days of services should not be applied to Medicare beneficiaries. There are adequate guidelines for inpatient rehabilitation hospital and unit services and outpatient services to determine medical necessity which are based on the patient's need and progress, not an arbitrary limit. The current Medicare inpatient and outpatient guidelines should be used.

We will be making these recommendations to HCFA as well.

II. Incentives

Under the various health care proposals, health care plans will be under great pressure to control costs. If they run out of funds their choices are to cut payments to providers or reduce services. These dynamics create a variety of incentives to under serve persons with extensive or special health care needs, particularly people who need rehabilitation services and persons with disabilities. These incentives exist in our health care system and are particularly problematic in managed care plans.

Managed care plans frequently place physicians at financial risk when they serve people who need intensive, on going services. This is particularly true for nonsalaried physicians who receive a capitated payment for each enrollee. Other plans attempt to pass on risk to providers in the form of financial incentives that lead to under service. These include bonuses or penalties to providers related to meeting, or exceeding, utilization limits and policies requiring physicians to assume the cost of out of plan specialty care. Other plans withhold a percentage of a providers' income if they exceed a targeted number of referrals to specialists and/or hospitalizations. These financial incentives coupled with any lack of awareness of the value of rehabilitation result in many people who need rehabilitation services and many people with disabilities not receiving needed care and remaining needlessly dependent at great cost to them and society. Or, they go out of plan and have to pay for the specialty care at great cost.

The NARF study found that 27% of the facilities that have contracts with HMOs for non Medicare enrollees said that the HMO does not refer enrollees to rehabilitation hospitals/ units. One-half of the facilities that have Medicare contracts reported that the HMO does not refer to rehabilitation hospitals/ units. Of those that do not refer Medicare enrollees, 57% said that the HMO states that it is not medically necessary; 25% said the HMO says care can be provided at a skilled nursing facility and 13% said that the HMO states that cost is the reason for not referring to rehabilitation hospitals and units.

Several studies raise concerns about HMO treatment of Medicare beneficiaries as well. The Medicare Advocacy Project, Los Angeles, California in its January 1993 report, "Medicare Risk-Contract HMOs in California: A Study of Marketing, Quality, and Due Process Rights" noted the following problems:

* Failure to refer for needed specialty care. The decision may not be made by the gatekeeper physician but by the medical group manager, utilization review coordinator or medical director. They also cited the physician financial incentive issues mentioned above.

* Not having enough contracting specialty physicians available or when the financial incentives delay referrals to specialty physicians.

* Failure to refer for rehabilitation. The frequency with which HMOs deny access to home health care and inpatient rehabilitation services... "raises questions about the financial incentives under which HMOs and their subcontracting provider groups operate." The report questions the HMOs determinations that cases that appear to meet the Medicare coverage guidelines were denied the care as not medically necessary.

Recommendations:

(1) Require that an individual with a) one of the conditions usually requiring rehabilitation services, b) with a congenital disability and/or c) with a specific functional status based on a functional assessment, receive a rehabilitation evaluation within 72 hours upon seeing a primary care provider or other gatekeeper. The conditions in question include, but are not limited to, stroke, spinal cord injury, congenital deformity, amputation, major multiple trauma, hip fracture, brain injury, all forms of arthritis, neurological disorders, burns, cancer, cardiac and pulmonary diseases and pain.

(2) Retain the point of service options under any health care reform proposal.

(3) Include standards that assure that physician referrals to physician and non-physician specialists are based solely on the needs of the patient. Financial incentives for referrals and/or for denying referrals should be prohibited.

(4) Allow persons needing rehabilitation services and persons with disabilities in particular to select a primary care provider or gatekeeper who is a physiatrist, an otherwise qualified rehabilitation physician or a specialist in the medical management of their particular condition. For example, the National Health Board could develop and publish a list of the conditions mentioned above usually requiring rehabilitation, chronic conditions and disabilities that are likely to require substantial specialized health care services. Health plans would establish panels of physicians who agree to serve as gate keeper physicians.

(5) Provide a separate case management system for people with traumatic brain and spinal cord injuries to prevent limits on coverage and failure to refer to the appropriate services and settings, thereby preventing these people from achieving their optimal recovery.

III. Quality Concerns

We are also concerned about the quality of care given to many HMO enrollees. This is a difficult issue to quantify. As noted, above we have heard about problems with people either not being referred at all for rehabilitation or being referred but with a limit on the number of days. Quality goes to the setting to which the patient is referred for services and the duration, frequency and type of treatment they receive. Our members have told us about enrollees, both Medicare and non-Medicare, being sent to what we characterize as a custodial institutional setting that provides either no or periodic skilled nursing and rehabilitation therapies as required under OBRA '90, but not a comprehensive rehabilitation program. Our members do not believe many of these patients obtain their maximum outcomes and rate of return to home, work, school and an active retirement are not as high as possible. This is a tragic personal, professional, familial, social and financial loss and burden.

The Medicare Advocacy Project Report cited above noted several cases where the HMOs approved less care than needed. The report states the "survey also points to possible systemic bias by some HMOs against referrals for in-patient rehabilitation services. All five of the southern California in-patient rehabilitation hospitals responding to MAP's survey felt that some Medicare HMOs denied medically necessary rehabilitation services to a greater extent than occurred in FFS [fee for service]." The report further states "some

HMOs appear to use arbitrary standards to deny or discontinue rehabilitation care." These standards include the patient's age even when a patient was improving.

The Mathematica study released in December, 1993 also raised concerns about quality of care. Mathematica looked at rates of death, hospital readmission and post admission complications as gross outcomes" measures but did not make any adverse findings. However it did state, "...a few differences do indicate that HMOs may be providing less adequate care in some situations. ...HMO stroke patients received significantly less physical therapy while in the hospital and had greater motor and speech deficits at discharge, yet were not more likely to have a post discharge speech or physical therapy plan. This pattern suggests that HMOs may economize on rehabilitation care...Although there is no evidence that these differences in care led to poorer patient outcomes, they cause some concern because of their potential adverse effect on outcomes."

The study noted that HMOs discharge a higher proportion of stroke patients to nursing homes and a lower proportion to rehabilitation hospitals. While it did not have follow up data, this practice raised concerns about whether this pattern was leading to poorer care.

Acceptance of outcomes as a measure of quality is well accepted in the rehabilitation field because of its focus on the functional status of the patient. Rehabilitation concentrates on the changes in function which occur during the course of treatment, as revealed by comparing patient status at the time of admission to the time of discharge. The continuation of these gains is monitored through follow up functional assessment after discharge. This acceptance of outcomes resulted in the development of several functional assessment measures in the rehabilitation field. The majority were developed for use in inpatient services. One is being adapted so that it can be used in a skilled nursing setting as well as an hospital inpatient setting. A patient classification system has also been developed for rehabilitation by NARF and the University of Pennsylvania. It is based on functional status at admission, age and impairment category. It uses 55 functionally related groups (FRG's) which classify patients by the resources needed to produce significant functional gains. An extension of this research will identify the characteristics that predict which patients require varying levels of care to obtain maximum functional gains.

However as these predictive tools are being developed and implemented we remain concerned that both Medicare and non Medicare enrollees continue to be sent to less intense rehabilitation service settings where they achieve less than maximum outcomes. They simply are not being allowed to function at the level at which they are able with appropriate therapies.

Recommendations:

1. HCFA should direct Medicare HMOs that they cannot use any arbitrary rules of thumb to deny care to Medicare beneficiaries, e.g. age. Furthermore, they cannot deny any Medicare benefits to beneficiaries. If an enrollee is a candidate for rehabilitation and meets the existing Medicare inpatient rehabilitation hospital or outpatient guidelines he or she should be referred for those services.
2. HCFA should increase its review of Medicare risk contractors' practices in referring to less intense levels of services patients who normally require rehabilitation.

IV. Americans with Disabilities Act

We are also concerned that all the practices outlined above lead to a lack of access to care that undermines the promise of the Americans with Disabilities Act given to the 49 million Americans with disabilities. The actions of HMOs in not covering rehabilitation care, not referring persons with disabilities for specialty care or referring them to settings where their outcomes are less than optimal should be viewed in this light and addressed immediately.

We would be pleased to discuss these critical issues with you Mr. Chairman.

**TESTIMONY OF CHARLETTE L. BEYERL
EXECUTIVE DIRECTOR/CEO
WISCONSIN INDEPENDENT PHYSICIANS GROUP, INC.**

Mr. Chairman and Members of the Committee:

On behalf of the member physicians of Wisconsin Independent Physicians Group, Inc. (WIPG), I am pleased to have the opportunity to submit written testimony for the hearing record. You have heard the isolated horror stories about Medicaid managed care programs that failed the populations they were to serve. Unfortunately, you seldom hear about the successful Medicaid managed care programs that provide for comprehensive, cost effective, quality medical care to the neediest populations. I wish to take this opportunity to tell you about one such program and what makes it work.

WHAT IS WIPG?

WIPG is a Managed Medical Provider Network comprised of 480 member physicians, nearly one third of whom are primary care providers. WIPG's physicians include private practitioners, community health center physicians, academic physicians in hospital based teaching clinics, and single and multiple specialty private clinics. WIPG also utilizes nurse practitioners and midwives to provide additional primary care support. The WIPG network includes 15 local area hospitals and contracts with independent sites for services such as radiology, laboratory, surgery and therapy. WIPG physicians currently provide medical care to 42,000 enrollees in the Milwaukee area, of which 94% are Medicaid recipients through the Wisconsin Medicaid HMO Initiative. WIPG arranges for the provision of all medical services for these enrollees and has been doing so, successfully, for the past 10 years.

WISCONSIN'S MEDICAID HMO INITIATIVE

The State of Wisconsin implemented the Medicaid HMO Initiative in 1984 by mandating that medical care for Milwaukee AFDC Medicaid recipients be provided through HMOs. HMOs submit bids annually to the State for Medicaid managed care contracts. Similar to certain proposals for health reform, the Medicaid recipients are free to choose their HMO from those who have contracted with the State. The recipients may also choose a provider network within the HMO they selected and choose a primary care physician. As a provider network for 40,000 Medicaid HMO Initiative enrollees, WIPG is the largest provider of Medicaid managed care in Milwaukee.

WHAT MAKES WIPG WORK?

The member physicians of WIPG follow several philosophies which have improved the quality and delivery of health care in a cost effective manner. Some examples are as follows:

Preventative Health Care Programs

WIPG monitors the medical care provided to its enrollees monthly to determine high or low utilization areas or changes in utilization that may indicate a problem. If a problem is identified, WIPG reviews methods for implementing preventative

programs or services that will reduce or prevent occurrence of the problem. For example:

Prenatal Support Program

Following a June, 1987 study of premature births during the preceding two years, WIPG developed the Prenatal Support Program (PSP) to help decrease the premature birthrate of WIPG enrollees. Policy objectives of the program include the goals of promoting early identification of high risk enrollees, promoting early prenatal education, and providing an aggressive follow-up for those members missing prenatal appointments.

The specific interventions used for enhancing prenatal care included:

- a. Mandatory Notification to PSP of all Enrollee Pregnancies
- b. Initial Home Visit including:
 - * completion of risk assessment,
 - * discussion of the risk factors assessed and ways to decrease the enrollee's risk of preterm delivery,
 - * client education related to pregnancy, general health, nutrition, prenatal care, fetus development and socio-economic assistance available through other agencies
 - * encouragement to comply with M.D. instructions and appointments.
- c. Use of Prenatal Risk Assessment Form including:
 - * enrollee's socioeconomic and demographic characteristics,
 - * previous medical history and daily habits,
 - * clinical characteristics of the current pregnancy,
 - * family history.

A copy of the risk assessment is forwarded to the enrollee's obstetrical provider.
- d. Ongoing Pregnancy Monitoring
- e. Pre-Delivery Home Visit including:
 - * a follow-up Risk Assessment
 - * client education regarding signs of preterm labor, warning signs during pregnancy, STD and other topics appropriate in the third trimester,
 - * discussion of transportation to the hospital and child care of siblings during hospitalization,
 - * discussion of newborn care,
 - * discuss postpartum plans for birth control.
- f. Post-Delivery Hospital Record Review for Mother & Infant
- g. Post-Delivery Obstetrical Provider Record Review

Prenatal Support Program Data Analysis

A comprehensive study was performed on the outcomes of women who were in the PSP and those who were not. The study was performed as follows:

- 1265 WIPG enrollees were studied
- 635 Participated in the Prenatal Support Program
- 630 Did not participate in the PSP

All enrollees were Wisconsin State Medical Assistance recipients

12 months of information was studied based on delivery dates

The analysis provided the following positive outcomes for those women who participated in the Prenatal Support Program:

PSP enrollees had fewer premature infants (over 20 wks and under 36 wks of gestation) than non-PSP enrollees

PSP enrollees had a higher number of prenatal visits to their PCP than non-PSP enrollees

PSP enrollees had a higher number of antepartum hospital days than non-PSP enrollees (necessary bed rest, etc.)

Lengths of stay in the hospital for both mothers and infants was lower on the average for enrollees in the PSP

The average cost to provide PSP services was less than the savings for improved birth outcomes

The infant mortality rate is lower for PSP enrollees than non-PSP enrollees

Prenatal Program Expansions

As a result of the positive outcome from the program, WIPG expanded the program to contact each new and re-enrolled WIPG female over the age of 17 to determine if she is pregnant. Those who are not pregnant are requested to contact their PCP for an annual physical. Those who are pregnant are scheduled with their PCP for a visit and with the PSP nurse for a visit.

As a result of the success of WIPG's Prenatal Support Program and the success of several pilot programs operated by the State in 1992, the State of Wisconsin implemented their Prenatal Care Coordination Program on January 1, 1994. This service is now available to all Medicaid recipients in the State.

Well Child Screens and Transportation

Through the HMO, notification is sent each time a well child (EPSDT) screen is due. These HealthCheck notices include:

- * the enrollee's primary care physician name, location, and telephone number,
- * the date the next HealthCheck is due,
- * offer for transportation arranged by the HMO to and from the visit (for the entire family if necessary),
- * assistance in establishing appointments, and
- * numbers to call for bilingual clarification of the notice and assistance.

Monitoring and Education of Providers

WIPG also utilizes its member physicians to participate on WIPG's Peer Review Committee and the various sub-committees such as its Pediatric Sub-committee and OB/GYN Sub-committee. These committees are charged with the responsibility of monitoring and improving the quality of care provided by their peers. These physicians also monitor current standards of care and recommended policies to the Board for implementation to assure that all WIPG physicians comply with the current standards.

Office Visits, Chart Review, and Staff Inservice

On at least an annual basis, a visit is made to each WIPG primary care provider by the Medical Director, nursing staff and operations staff to perform a site visit. The visits include:

- * chart reviews by WIPG's nursing staff to assure proper documentation and verification of appropriate provision of services,
- * a site and equipment inspection to assure cleanliness, safety, and quality of site and equipment,
- * an inservice with the physicians staff to reinforce policies and procedures and assistance with any difficulties they may be experiencing,
- * review with the physician by the Medical Director of the prior years utilization, outcomes of cases and a request for recommendations from the physicians for areas of concern about the wellness of WIPG enrollees they serve.

These visits have been valuable to assure that quality care is provided to the Medicaid population and to assist physicians and their office staff with questions or problems they may have. These visits are viewed as positive by the physicians and many are anxious to show the improvements that have been made since the last site visit.

RESULTS OF THE PROGRAM

The State of Wisconsin reported the following decline in utilization of unnecessary services as a result of implementation of the Medicaid HMO Initiative:

- 53% decrease in hospital days per 1,000
- 30% decline in admissions
- 33% reduction in the length of stay
- 11% decrease in physician office visits per person
- 31% drop in lab and x-ray procedures
- 19% reduction in ambulance runs, and
- 27% decrease in emergency room visits.

In October, 1993 the State released their HMO, Fee For Service Comparison Report for calendar 1992 dates of service. This report compares the results of Medicaid recipients in the HMO Initiative to recipients who receive services under the State's traditional fee for service Medicaid program. When compared to fee for services recipients the HMO Medicaid Enrollees had:

- * over 3% lower cesarean section rate
- * twice as many HealthCheck screens
- * a lower number of sick child visits
- * an equal number of visits per recipient
- * 63% higher level of childhood immunizations
- * a higher level of lead tests and sickle cell screens
- * a higher level of utilization for mental health/AODA services
- * a higher level of pap smears
- * a comparable level of mammographies
- * 60% fewer emergency room visits
- * a higher proportion of enrollees seen by primary care physicians

These results speak for themselves regarding the value of Wisconsin's Medicaid Managed Care Program.

WHAT'S NEXT FOR WIPG?

WIPG has identified, addressed and implemented many programs which have improved access and quality of care to Medicaid recipients, but there are many issues that concern WIPG that you as policy makers can impact. For instance:

- * A review of the many successful programs across the United States shows that Medicaid services provided successfully under managed care improved access, quality and health outcomes at reasonable costs. This provides a model that may be useful in health care reform.
- * As stated earlier, WIPG has provided Medicaid recipients with access to quality care, stressed preventative care, and made transportation available to obtain care. In spite of these efforts it is still illegal for WIPG to force an individual to obtain health care if they don't want it. Health reform should require that individuals, not only Medicaid recipients, take responsibility for their health and the health of their children if it is made available to them. A deduction is allowed from Federal income taxes for each dependent child,

but there is no responsibility or proof required that the child has been immunized or had a health screen. Individuals reapplying for welfare are not required to provide proof that their children have received these minimal health services. Health reform should improve the health of the nation in addition to providing for access.

- * Many states, including Wisconsin, currently require that school children be immunized. In Milwaukee, the rate of immunized school child is almost 100% which proves that these requirements can improve preventative health compliance. These requirements could easily be expanded to include well child screening which would also detect other health concerns.

CONCLUSION

In conclusion I would like to leave you with a few brief statements.

Managed Care can improve access, quality and outcomes while limiting cost increases. The statistics I have provided show that even with the very needy Medicaid population, managed care can be successful. Managing care includes management of providers, costs, and services, not just the patients.

Health Reform should require that individuals be responsible for their health and the health of their children. Legislating, mandating and regulating health care providers, the insurance industry and employers will not improve the health of the people in the United States. Individuals must take responsibility for obtaining health care, particularly preventative care, for themselves and their children if health reform makes it available to them.

Wellness of individuals is obtained by combining medical services and social services. WIPG's Prenatal Support Program was a social intervention that assisted recipients to obtain medical care through the sources that were available. That social assistance was key to increased prenatal visits and compliance. Providing this alternative service actually decreased total health care costs.

Thank you for the opportunity to present this information. Please do not hesitate to contact me if I can provide additional information.



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